THE LOS ANGELES COUNTY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

A Proposal to the California Department of Mental Health
in Accordance with the Mental Health Services Act

October 2005

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THE LOS ANGELES COUNTY MENTAL HEALTH SYSTEM'S COMMUNITY SERVICES AND SUPPORTS PLAN

PART I: COUNTY/COMMUNITY PUBLIC PLANNING PROCESS AND PLAN REVIEW PROCESS

PART I, SECTION I: Planning Process

1) Briefly describe how your local public planning process included meaningful involvement of consumers and families as full partners from the inception of planning through implementation and evaluation of identified activities.

Since December 2004, thousands of people across Los Angeles County have participated in a fast-paced planning process to develop the first draft of a Community Services and Supports Plan.

Participants included people who are receiving services, family members, community leaders, community service providers, staff from the Los Angeles County Mental Health Department, staff from other County Departments, and many others. People of all ages have participated in this planning process, including youth 13 years and older and people well over 70. We have had people from many ethnic and racial communities participate, including members of African American, Armenian, American Indian, Cambodian, Chinese, Hispanic, Korean, Latino, Persian, Russian, Tongan, Western European, and many other racial and ethnic communities.

The Los Angeles County planning process for the Community Services and Support (CSS) Plan is continuing to unfold through several different structures. Sixty-three delegates, chosen from over 40 different stakeholder groups, have made all formal decisions during this process. People who receive services and family members, including caregivers of young children, are well-represented as delegates and alternates.

While stakeholder groups formally choose the delegates and alternates who participate in the decision-making process, participation in all other structures is open: anyone who wants to participate can. The work of the delegates is supported by a variety of other work structures, including five countywide workgroups, myriad ad hoc workgroups, and the Service Area Advisory Councils. The Board of Supervisors divided Los Angeles County into eight service areas to facilitate planning within and among County departments. Each Service Area has a Mental Health Service Area Advisory Council that includes people who receive mental health services, family members, mental health service providers, and County Department representatives. Consumers, family members, and advocates actively participate in the work of the countywide workgroups, the ad hoc workgroups, and the Service Area Advisory Councils.

We have offered modest stipends and transportation vouchers to participants, and invested substantial resources in oral and written translation services to facilitate the participation of people who receive services and families.

In addition to these more formalized work structures, we have conducted an aggressive education and training campaign to help people who receive services, family members, and other stakeholders learn about the Mental Health Services Act and the CSS planning process. Between mid-July, after delegates had reached agreement on the framework for the plan, and September 9, the last day of the thirty-day comment period, we conducted over 200 community engagement sessions involving more than 5000 people. These meetings were organized and supported by community members, people receiving services, family members, DMH staff, community based providers and many others. People were encouraged during these sessions, to give us feedback both through small group dialogue as well as through written feedback. Family members and people who receive services were a substantial majority of the participants in the forums conducted during the 30-day comment period.

2) In addition to consumers and family members, briefly describe how comprehensive and representative your public planning process was.

The planning process has proceeded through three stages to date:

Phase One: We organized an expansive community process that began in December, 2004 and concluded in March, 2005. This process produced 930 pages of assessment and analysis of the current system and a broad array of preliminary recommendations about how to improve it. Over 30 ad hoc countywide groups formed and participated; in addition, each of the eight Service Area Advisory Councils organized three or more sub-groups to participate in this process as well. Beyond this assessment work, this phase also produced multiple trainings for stakeholder and other groups in the fundamentals of the Mental Health Services Act and how the planning process would unfold in Los Angeles County.

Phase Two: Five countywide workgroups formed to begin work specifically focused on the CSS Plan. The five workgroups included:

- Children 0-15;
- Transition Aged Youth 16-25;
- Adults 26-59;
- Older Adults 60 and older; and
- Under-represented (and Inappropriately Served) Ethnic Populations.

These groups met intensively in full-group and ad hoc workgroup sessions between late April and mid-June, 2005 to draft a series of recommendations for their age group or area of focus for consideration and revision by the delegates. Each workgroup had a participant list of well over 100 people, and included substantial representation from people who receive services, family members, advocates, community-based providers,

members of the Service Area Advisory Councils, various Departments, and other groups.

This phase of work continued the trainings on how to participate in the planning process and was delivered in multiple languages to groups across the County. It also included trainings in the recovery model and in various dimensions of Full Service Partnerships as well as systems development.

Phase Three: Beginning in mid-June sixty-three delegates from more than forty Stakeholder groups began meeting in half-day and full-day sessions to review the recommendations from the five countywide workgroups. On average, more than 200 people attended each of the 10 delegate meetings that occurred between June 13 and July 25, 2005. Dozens of ad hoc workgroup sessions also occurred during this period to address issues that arose during the delegates' deliberations.

The delegates' meetings had two fundamental foci: first, to educate the delegates and others about the various recommendations from the Countywide workgroups and about the evolving State guidelines; and second, to engage the delegates in a consensus building process to develop the first draft of the CSS Plan.

We published the draft of our CSS Plan on August 9, 2005, reflecting the consensus achieved among the delegates and stakeholder groups on the overarching budget, and the priority programs and strategies for the first three years. Between mid-July, after delegates had reached agreement on the framework for the plan, and September 9, the last day of the thirty-day comment period, we conducted over 200 community engagement sessions involving more than 5000 people. These meetings were organized and supported by community members, people receiving services, family members, DMH staff, community based providers and many others. These sessions:

- Occurred across all 8 Service Areas.
- Engaged people across all four age groups.
- Engaged multiple special populations, including people who are currently homeless, older adults who are homebound, people who are deaf or hearing impaired, parent groups, faith-based groups, probation officers, HIV clinic patients, social workers, people who are gay, lesbian, or transgender, people in the jails and other institutional settings, and many others.
- Included 127 sessions conducted in 13 different languages other than English, including 58 sessions in Spanish only, 19 sessions in Spanish and English, 9 in Korean, 8 in Armenian, 6 in Japanese, 5 in Thai, 4 in Russian, 4 in Tagalog, 3 in mixed language, 2 in Cambodian, 2 in Cantonese, 2 in Farsi, 1 in Mandarin, 1 in American Sign Language, 1 in Hindi, 1 in Urdu, and 1 in Vietnamese.

All told, since February 2005 we have conducted almost 90 working sessions on various aspects of the plan, including delegates meetings, countywide workgroup meetings, and ad hoc workgroup meetings. The total number of participants in all sessions for which we have documentation since February 2005, including the working sessions, the

community engagement and training sessions analyzed above, and other specialized training and engagement sessions, is over 11,000.

3) Identify the person or persons in your county who had overall responsibility for the planning process. Please provide a brief summary of staff functions performed and the amount of time devoted to the planning process to-date.

The Director of the Department of Mental Health has the administrative responsibility for the overall planning process. He assigned a full time Mental Health District Chief (100%), and four administrative staff (100%) to support five contracted consultants (25%) plus the lead consultant (75%) who reports directly to the Director.

In addition, five Department of Mental Health Program Deputies (20%) and their staff (30%) have had the responsibility of convening meetings and managing the communication process for each of the five workgroups (four age groups plus the countywide Under-Represented and Inappropriately Served Ethnic Population (UREP) workgroup). A Chief Research Analyst was reassigned part time (50%) to MHSA activities to coordinate the collection and analysis of data. Staff members throughout the Department of Mental Health including District Chiefs and their staff from the eight Service Planning Areas (SPA), representative from the Office of Consumer Affairs, the Mental Health Commission support staff, the Public Information Officer, and a Parent Advocate have dedicated at least 15% of their time to conduct and promote outreach, training and other activities that encourage community involvement, specifically from the unserved and underserved populations within Los Angeles County.

a) Provide the name of the person with overall responsibility for the public planning process in your county and the percentage of their time devoted to the effort.

NAME	TITLE	% TIME
MARVIN J. SOUTHARD, DSW	DIRECTOR, LA COUNTY DEPT. OF MENTAL HEALTH	20%
OLIVIA CELIS-KARIM, MPL, LCSW	MH DISTRICT CHIEF, LA COUNTY DEPT. OF MENTAL HEALTH	100%

b) Provide the names and titles of other persons who supported the public planning process; identify their function and how much time they each devoted to the effort.

PUBLIC PLANNING ROSTER

NAME	TITLE	% TIME
John G. Ott	Principal Consultant	75%
Jose Montano	Community Training & Engagement and Underserved Ethnic Consultant	25% - 50%
Rose Pinard	Older Adult Workgroup & Underserved Ethnic Communities Consultant	25%
Tessa de Roy	TAY and Children's Workgroup Consultant	40%
Rigoberto Rodriguez	Children's Workgroup Consultant	25%
Pat Bowie	Adult Workgroup Consultant	15%
John Hatakeyama	Children's Deputy Director - DMH	20%
Sam Chan	Children's Countywide Programs - DMH	20%
Cora Fullmore	Justice Programs Deputy Director - DMH	20%
Dean Whitehead	Justice Programs Administration	20%
Jim Allen	Adult Deputy Director - DMH	20%
Kathy Daly	Adult Medical Director - DMH	20%
Yvette Townsend	Older Adult Deputy Director - DMH	20%
Kevin Tsang	Older Adult Administration - DMH	20%
Joellen Perkins	District Chief – Service Planning Area I	15%
Natalie Ambrose	Coordinator Consultant - Service Planning Area I	15%
Eva Carrera	District Chief – Service Planning Area II	15%
Eileen Maronde	Administration – Service Planning Area II	15%
Carlotta Childs	District Chief – Service Planning Area III	15%
Jaime Renteria	Administration – Service Planning Area III	15%
Ana Suarez	District Chief – Service Planning Area IV	15%
Karen Williams	District Chief – Service Planning Area V	15%
Mark Wells	Administration – Service Planning Area V	15%
Renee Woodruff	District Chief – Service Planning Area VI	15%
Sandra Thomas	District Chief – Service Planning Area VI	15%
Edward Vidaurri	District Chief – Service Planning Area VII	15%
Debbie Innes-Gomberg	District Chief – Service Planning Area VIII	15%
Anthony Cooksie	Administration – Service Planning Area VIII	15%
Carmen Diaz	Office of the Parent Advocate	25%
John Griffith	Office of the Family Advocate	15%
Ron Schraiber	Office of Consumer Affairs	15%
Gwen Lewis-Reid	Office of Consumer Affairs	15%
Terry Lewis	Mental Health Commission Administration Staff	15%
Kirsten Deichert	Public Information Officer	25%
Yolanda Sanchez	MHSA Planning – Administrative Support	100%
Ken Sholders	MHSA Planning – Administrative Support	100%
Norma Roman	MHSA Planning - Secretary	100%
La Shanda Brown	Data Research and Analysis	50%

At least as important to this process, however, has been the perseverance and steadfast commitment of hundreds of people across the county, including the sixty-three delegates and countless other community and County leaders who have dedicated thousands of hours to help craft this plan.

4) Briefly describe the training provided to ensure full participation of stakeholders and staff in the local planning process.

As noted previously, we have engaged in an aggressive process of outreach and engagement as part of the planning process for the Community Services and Supports plan. Central to this effort has been our effort to provide stand-alone trainings and trainings embedded within workgroup, delegates, and other meetings to ensure that people who receive services, family members, and stakeholders across the County could engage as full-on participants in the process. These training sessions have not only focused on how to get participants involved in the planning process, but also on particular aspects of the plan and the larger Mental Health system, including:

- Understanding the Mental Health Services Act;
- Committing to the essential elements of recovery;
- Fundamentals of community engagement and organizing;
- Understanding the County Mental Health budget;
- Understanding Full Service Partnerships;
- Understanding the State Guidelines governing the CSS Plan;
- Working with demographic and focal population data;
- Principles and practices of consensus decision-making;
- Creating a transformed service delivery system; and
- Myriad other topics relevant to the CSS planning process.

PART I, SECTION II: Plan Review

1) Provide a description of the process to ensure that the draft plan was circulated to representatives of stakeholder interests and any interested party who requested it.

The draft plan has been circulated widely among stakeholder groups across the County since its posting on the Department's website on August 9, 2005. While anyone who wished to do so could download the plan off the website, we also developed a proactive strategy for circulating the plan and soliciting feedback. Service Area Advisory Councils and community groups across the County have conducted meetings on the plan. To assist with these discussions, the Department's Training and Cultural Competency Bureau, Public Information Office, process consultants, and a number of key community partners developed a range of materials, including summary PowerPoint presentations and talking points, translated into multiple threshold languages, that highlight essential elements of the plan.

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- Included 127 sessions conducted in 13 different languages other than English, including 58 sessions in Spanish only, 19 sessions in Spanish and English, 9 in Korean, 8 in Armenian, 6 in Japanese, 5 in Thai, 4 in Russian, 4 in Tagalog, 3 in mixed language, 2 in Cambodian, 2 in Cantonese, 2 in Farsi, 1 in Mandarin, 1 in American Sign Language, 1 in Hindi, 1 in Urdu, and 1 in Vietnamese.

2) Provide documentation of the public hearing by the mental health board or commission.

The public hearing held on September 20, 2005 was the culmination of this aggressive outreach effort. Over four hundred people attended the public hearing, including 129 people who receive services and family members, ninety-two representatives from community organizations and agencies, and a range of other interested stakeholders, including clergy, representatives from SEIU 660, representatives from LA DMH and other county departments, and many others. We offered translation services in six different languages.

One of our objectives for this public hearing was to attract many people who had not yet been engaged in the process; at least 86 people indicated in their small groups that the public hearing was their first meeting; another 191 indicated they had attended only a few meetings on the plan.

Participants in the public hearing had three opportunities to be heard: first, through small group conversations following a brief presentation about the plan; second through individual comment sheets made available to every participant; and third, through public comment during the large group discussion.

We received 57 summary sheets from small group conversations; 90 individual comment forms (including 15 table summary forms that were filled out by individuals); and dozens of public comments during the large group discussion. While we will

conduct a more thorough analysis of the public hearing data, together with the data from the community engagement sessions, over the next several weeks, broad themes are already apparent.

The small group discussion summaries revealed overwhelming support for every aspect of the plan. The questions from these small group discussion summaries focused primarily on how questions, including:

- How will the plan address disparities in access to services?
- How will the plan improve outcomes for those most severely in need?
- How will the plan address housing needs?
- How will the plan *really* demonstrate an on-going commitment to recovery?

Given the large percentage of people who had little or no exposure to the planning process or the plan prior to this hearing, these questions are to be expected. Moreover, such questions suggest agreement on the intention of the plan, focusing instead on whether the plan and the people who will implement it will actually achieve what the plan promises.

The responses in the individual comment sheets reflected a similar pattern. People expressed appreciation for all aspects of the plan, with a number of respondents specifically identifying the following highlights:

- The inclusive process;
- Housing;
- Specific attention to different age groups;
- Core values, including recovery, hope, multicultural access, focus on outcomes;
- Full service partnerships; and
- Co-occurring services.

In response to the question of what could be improved in the plan, the pattern of responses from the individual feedback forms matched the pattern of comments made during the large group discussion at the end of the public hearing. In both contexts people expressed appreciation for the plan and the process, but wanted to know:

- Would they or their family members be included in the plan and eligible for services? Hispanic family members, people who are hard of hearing, people who themselves or their family members have a developmental disability, Asian family members, and many others gave voice to this question.
- How would the plan address the needs of individuals in, transitioning out of, or being diverted from jails?
- How could homeless people and others access the housing options through this plan?
- How could people learn about the plan earlier, and how can they get involved now?

- How will the plan address the particular needs of different ethnic and racial communities–e.g., Native American communities, Hispanic communities, Asian and Pacific Islander communities?
- How will the plan insure that practitioners are grounded in a commitment to recovery?
- How will we continue the education and outreach process after the plan is submitted?
- How will the plan support the expansion of peer support and self-help groups?

All of these questions are important, and were thoroughly explored by the Countywide workgroups and the delegates in the months of work that produced the consensus draft Community Services and Supports plan. As we have reflected upon the data that emerged from the public hearing and the broader community engagement process, the Mental Health Commission, Department leadership, and the delegates to the Stakeholder process have concluded together that:

- We are on the right track.
- There is broad agreement across multiple communities and stakeholder groups about the directions we are taking in the plan.
- The data from these engagement efforts will be very helpful in the design and implementation phases of our work.
- We are building very effective capacity to engage a broad array of people across the County in dialogue and discernment about mental health issues, capacity that will be essential as we move forward to implement the CSS plan.

We are proud of the work we have done both to craft the Community Services and Supports Plan, and to reach out to a broad cross-section of the Los Angeles County community to take stock of this draft plan. The hard work of implementation now lies ahead. We no doubt will learn much over the coming months as we move to implement the plan, and will of course explore ways to change and improve the plan over time.

3) Provide the summary and analysis of any substantive recommendations for revisions.

Please see the response to question 2) above.

4) If there are any substantive changes to the plan circulated for public review and comment, please describe those changes.

The plan we originally posted for public review and comment on August 9 is substantially different in *form* from the plan that we now submit for approval. Our intention was to post a version of the plan that would clearly and accessibly articulate the consensus reached among the sixty-three delegates from over 40 different stakeholder groups. The essential content of the plan, however, including the budget agreements and essential descriptions of the commitments at the heart of the plan, remain unchanged.

PART II: PROGRAM AND EXPENDITURE PLAN REQUIREMENTS

PART II, SECTION I: Identifying Community Issues Related to Mental Illness and Resulting from Lack of Community Services and Supports

1) Please list the major community issues identified through your community planning process, by age group. Please indicate which community issues have been selected to be the focus of MHSA services over the next three years by placing an asterisk (*) next to these issues. (Please identify all issues for every age group even if some issues are common to more than one group.)

In preparation for the CSS planning process, Los Angeles County stakeholders engaged in an expansive community needs and strengths assessment process. Over 2000 people participated and produced almost 1000 pages of data and recommendations regarding the challenges and issues affecting the various age groups, ethnic populations, and other special populations across the County.

This information provided a starting point for the five countywide workgroups to begin their work to provide recommendations to the stakeholder delegates. Through intensive dialogue and analysis, the countywide workgroups identified the following priority issues for each of the four age groups to be addressed by the first iteration of the CSS plan:

CHILDREN	TAY	ADULTS	OLDER ADULTS
* Children being removed from their families by the Department of Children and Family Services because of mental health issues affecting the children, other family members, or both	* Young people involved in child welfare and probation systems because of mental health issues. The lack of supports and services for these youth as they transition out of these systems.	* The frequent cycle suffered by many adults struggling with mental health issues that sees people cycle between: homelessness, institutionalization, incarceration, and emergency rooms	* Lack of understanding and commitment for addressing mental health issues among the older adult population from policymakers, clinicians, community leaders, and others
* Children suffering because their parents or caregivers, including teen parents, have SED or severe and persistent mental illness	* Invisibility: Many transition age youth who suffer from mental health issues are highly transient and therefore present challenges for developing trusting relationships that can lead to effective services and supports being provided	* Co-occurring disorders, particularly substance abuse disorders	* Significant differences in needs and issues affecting younger older adults (60—65) and older adults

CHILDREN, CONTINUED	TAY, CONTINUED	ADULTS, CONTINUED	OLDER ADULTS, CONTINUED
* School issues, including: (a) Truancy (b) Expulsions and suspensions from schools (c) Violent behaviors at school (d) School failures	* Transition age youth and their families who suffer from co-occurring disorders, particularly substance abuse disorders	* Lack of adequate transition facilities to help people move out of institutional settings and into more community based settings	* Lack of the basic resources and infrastructure for a system of care for older adults
* Children and youth who are involved with the Juvenile Justice System because of mental health issues	* Transition Age Youth who are homeless, and who lack safe, affordable permanent housing	* Adults who are homeless, and who lack safe, affordable, permanent housing	* Lack of effective data documenting the needs of this population
* Children, youth, and their families who suffer from co-occurring disorders, particularly substance abuse disorders	* Frequent lack of family engagement in issues affecting TAY	* In many communities, lack of awareness and acceptance of mental health issues	* Multiple barriers to accessing services—e.g., providing effective services to people who are homebound
* Lack of culturally aware and competent services and supports	* Lack of culturally aware and competent services and supports	* Lack of culturally aware and competent services and supports	* Lack of culturally aware and competent services and supports

2) Please describe what factors or criteria led to the selection of the issues starred above to be the focus of MHSA services over the next three years. How were issues prioritized for selection? (If one issue was selected for more than one age group, describe the factors that led to including it in each.)

In selecting these priority issues, workgroups focused on a number of strategic considerations, including:

- The focus of the state CSS guidelines on adults and older adults with the most severe and persistent mental illness, and on children and youth who struggle with the most severe emotional disturbances;
- The commitment to use MHSA funds to help leverage change that goes well beyond the immediate impact of the new dollars;
- The relative flexibility of the MHSA funds compared to other resources available for mental health services to address some of the community's most intractable issues and most vulnerable populations;
- The desire to create early successes to build momentum for larger-scale change; and
- The desire to address, in concrete ways, issues of disparities in access to services and disparities in outcomes.

3) Please describe the specific racial ethnic and gender disparities within the selected community issues for each age group, such as access disparities, disproportionate representation in the homeless population and in county juvenile or criminal justice systems, foster care disparities, access disparities on American Indian rancherias or reservations, school achievement drop-out rates, and other significant issues.

The priority needs identified by the stakeholders for each age group are analyzed in terms of racial, ethnic, and geographic disparities, and gender disparities where significant, using the most current data sources available. In most cases, this is FY 2002-03 data.

CHILDREN 0-15

The priority issues for children identified by the Stakeholders to be addressed by the CSS plan include:

- Children being removed from their families by the Department of Children and Family Services because of mental health issues affecting the children, other family members, or both.
- Children suffering because their parents or caregivers, including teen parents, have SED or severe and persistent mental illness.
- School issues, including:
  - Truancy
  - Expulsions and suspensions from schools
  - Violent behaviors at school
  - School failures
- Children and youth who are involved with the Juvenile Justice System because of mental health issues.
- Children, youth, and their families who suffer from co-occurring disorders, particularly substance abuse disorders.
- Lack of culturally aware and competent services and supports.

Very little specific data exists to help us document patterns of racial, ethnic, and geographic disparities within these issues. The data we do have is summarized below.

Disparities among Children within Poverty and Uninsured Populations
Poverty and lack of access to resources are general indicators of need for mental health services that we use when more specific data does not exist.

- In 2003, 2,485,090 children (ages 0-15) lived in the County. The gender and ethnic composition of this population was as follows:

CHILDREN IN GENERAL POPULATION BY GENDER		
Female	1,213,633	48.84%
Male	1,271,457	51.16%
Total	**2,485,090**	**100%**

CHILDREN IN GENERAL POPULATION BY ETHNICITY		
African-American	244,771	9.85%
American Indian	6,932	0.28%
Asian/Pacific Islander	249,409	10.04%
Hispanic	1,509,338	60.74%
White	474,640	19.10%
Total	**2,485,090**	**100%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Of these children, 678,182 (27.29%) lived at or below 200% of federal poverty guidelines. The gender and ethnic composition of children living at or below 200% of federal poverty guidelines was as follows:

CHILDREN IN POVERTY BY GENDER		
Female	333,143	49.12%
Male	345,039	50.88%
Total	**678,182**	**100%**

CHILDREN IN POVERTY BY ETHNICITY			
	N	**% of Poverty Population**	**% of Total Ethnic Pop (Previous Table)**
African-American	89,101	13.14%	36.40%
American Indian	3,189	0.47%	46.00%
Asian/Pacific Islander	42,430	6.26%	17.01%
Hispanic	499,320	73.63%	33.08%
White	44,142	6.51%	9.30%
Total	**678,182**	**100%**	

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- The geographic distribution of this poverty population was as follows:

CHILDREN IN POVERTY BY SERVICE AREA OF RESIDENCE		
1 - Antelope Valley	23,721	3.50%
2 - San Fernando/Santa Clarita Valley	102,597	15.13%
3 - San Gabriel Valley	91,803	13.54%
4 - Metro	103,111	15.20%
5 - West	15,986	2.36%
6 - South	139,301	20.54%
7 - East	90,688	13.37%
8 - South Bay	110,975	16.36%
Total	**678,182**	**100%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Data for uninsured households is much less precise. We have countywide ethnicity data, and data by Service Area, but not data by ethnicity by Service Area. The data we do have reveal the following patterns:

UNINSURED CHILDREN 0-15 BY ETHNICITY		
Latino	127,000	73.41%
American Indian/Alaska Native	1,000	0.58%
Asian	13,000	7.51%
African American	16,000	9.25%
White	14,000	8.09%
Other single/2 or more races	2,000	1.16%
Total	**173,000**	**100%**

UNINSURED CHILDREN 0-15 BY SERVICE AREA OF RESIDENCE		
1 - Antelope Valley	7,000	4.05%
2 - San Fernando/Santa Clarita Valley	46,000	26.59%
3 - San Gabriel Valley	30,000	17.34%
4 - Metro	19,000	10.98%
5 - West	2,000	1.16%
6 - South	25,000	14.45%
7 - East	27,000	15.61%
8 - South Bay	17,000	9.83%
Total	**173,000**	**100%**

Source: UCLA, 2003 California Health Interview Survey (CHIS)

- This data reveals familiar patterns in Los Angeles County: high concentrations of poverty among Hispanic, African-American populations, and American Indian children. The data also shows somewhat higher rates of uninsured children for American Indian and Asian and Pacific Islander children relative to their percentages in the overall population.

Involvement with DCFS
Countywide in 2003, 62,482 children under 18 years of age were clients of the Department of Children and Family Services (DCFS). Note the age range for this analysis is 0-18 rather than 0-15. Current data sources do not permit a more precise analysis for children 0-15.

- Of the 62,482 children 0-18 who were DCFS clients:
  - 4,162 children were in D-Rate facilities. Of these children, 74.31% had received some form of DMH services during FY 2002-2003.
  - 19,041 (30%) children received at least one mental health service from DMH within FY 2002-2003. An additional 9,221 (14%) children of the children involved in DCFS had received mental health services from DMH some time prior to FY 2002-2003.

- Of the DCFS children who had received services from DMH during FY 2002-2003 or prior, 9,229 (32%) were African American, 14,059 (49.97%) were Hispanic, and 2,860 (13.48%) children were White.

Involvement with the Juvenile Justice System
In 2003, 11,088 children (ages 0-18) who were detained within the juvenile justice system were treated with psychotropic drugs at least once by DMH.

- Nearly a quarter of these children (23%) lived in Service Area 6.
- Of these 11,088 children, 2,870 (25%) children were African American and 4,473 (40.33%) children were Hispanic. The number of American Indian children (37 children) and the number of Asian American children (185 children) were cumulatively less than 2% of the overall population. The ethnic origin for more than 2,500 children (24%) within this overall population is unknown.
- A significant majority of the children within this population, estimated at 68%, is approaching or is already within the transitional age youth group.
- Boys typically constitute significant majorities of those involved in the juvenile justice system.

In future years, DMH and the stakeholders will work to develop additional data sources to augment these findings.

Lack of Culturally Aware and Competent Services and Supports
Section V of this document includes a detailed analysis of the cultural competency of DMH and its providers. Unfortunately, the data available to DMH for analysis of cultural

competence is not age-specific. This is a significant area of concern to the stakeholders because county experience, in the judgment of stakeholders, shows that the lack of culturally appropriate community services and supports creates significant barriers to services for children of myriad ethnic and cultural groups. DMH and the stakeholders will augment this finding with quantitative data and analysis in future years.

Other Community Issues and Data Sources

The other community issues of significant concern to the stakeholders included: (1) children being removed from their families by the Department of Children and Family Services due to mental health issues affecting the children, other family members, or both; (2) children of parents with SMI or co-occurring disorders; and (3) children with school issues due to SMI. At the current time, however, we lack reliable data sources for further analysis.

The Stakeholders have substantial experiential data about how these issues cause significant disruption to the healthy development of children within our county. The stakeholders have made the creation of new data sources and the strengthening of existing data for effectively addressing these issues over time a high priority.

The following tables present more detailed data by Service Area to further support the analysis above. Note that some of the data sources by Service Area use different age ranges, creating some anomalies between the Countywide and Service Area analysis. While the totals vary somewhat, the patterns described above remain consistent.

Notes on Table Sources for Children (ages 0-15 unless otherwise specified)
Focal Population Proxies analyzed by Age Group, Service Area, and Ethnicity

[a] *Hedderson, J. & Bixler, J., Walter R. McDonald & Associates, Inc. Sacramento, CA.* Countywide poverty population estimates published during the MHSA stakeholder process do not vary; however, when the estimates are broken into small categories, such as Service Area and ethnicity or into even smaller sub-categories such as ethnicity within Service Area, the sub-total (category totals) will vary somewhat.

[b] *Urban Research, Service Integration Branch, Los Angeles, CA*. Includes children/youth living at or below the 200% Poverty Level in Los Angeles County as of July 1, 2003.

[c] *Los Angeles County Department of Children and Family Services (DCFS).* DCFS Active Caseload by Age Range, Ethnicity, and Current Location Service Area: (a) for children in Out-of-Home Placement, the current location Service Area is determined by the child's current placement location address and (b) for children receiving DCFS services in-home, the current location Service Area is determined by the child's residence address.

[d] *LAC-DMH Planning Files, FY 2002 – 2003*. Juvenile Justice summarizes the number of juveniles who were prescribed psychotropic medications at least once during FY 02-03. This value includes drugs administered by Short-Doyle providers. This value does not include drugs administered by general practitioners or by fee for service providers.

Children ages 1 - 15 years	Children 0 - 5 years living at or Below 200 % Poverty Level [3]		Children 6 - 11 years living at or Below 200 % Poverty Level [3]		Children involved with DCFS [4]		Children/ Youth involved with Juvenile Justice who received Psychotropic medications [5]	
Service Area (SA)	*N*	*%*	N	*%*	*N*	*%*	*N*	*%*
[redacted]								
African American	2,551	30.26	8,049	30.30	1,143	40.56	186	40.09
American Indian	67	0.79	196	0.75	10	0.35	4	0.86
Asian/Pacific Islander	67	0.79	444	1.67	17	0.61	0	0.00
Hispanic	4,086	48.46	11,614	43.72	818	29.03	117	25.22
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	9	0.32	78	16.80
White	1,661	19.70	6,259	23.56	821	29.13	79	17.03
Total	**8,432**	**100.00**	**26,562**	**100.00**	**2,818**	**100.00**	**464**	**100.00**
[redacted]								
African American	1,774	4.80	6,877	5.89	399	12.62	346	17.56
American Indian	231	0.63	586	0.50	24	0.76	7	0.36
Asian/Pacific Islander	1,767	4.79	7,314	6.27	91	2.88	32	1.62
Hispanic	27,498	74.47	78,420	67.19	1,806	57.12	980	49.75
Other	0	0.00	0	0.00	0	0.00	0.00	0.00
Unknown	0	0.00	0	0.00	15	0.47	327	16.60
White	5,653	15.31	23,514	20.15	827	26.15	278	14.11
Total	**36,923**	**100.00**	**116,711**	**100.00**	**3,162**	**100.00**	**1,970**	**100.00**

Children Ages 1 - 15 years	Children 1 - 5 years living At or Below 200 % Poverty Level[1]		Children 6 - 15 years living At or Below 200 % Poverty Level[1]		Children involved with DCFS[2]		Children/Youth involved with Juvenile Justice who received Psychotropic medications[3]	
SA	*N*	%	N	%	*N*	%	*N*	%
[redacted]								
African American	1,691	5.14	6,699	6.26	863	17.10	208	15.37
American Indian	203	0.62	562	0.52	43	0.85	5	0.37
Asian/ Pacific Islander	[illegible]	15.83	20,855	19.45	286	5.67	42	3.10
Hispanic	24,277	73.80	70,772	66.01	3,154	62.48	590	43.61
Other	0	0.00	0	0.00	0	0	0	0
Unknown	0	0.00	0	0.00	18	0.35	391	28.90
White	1,517	4.61	8,319	7.76	684	13.55	117	8.65
Total	**32,894**	**100.00**	**107,207**	**100.00**	**5,048**	**100.00**	**1,353**	**100.00**
[redacted]								
African American	1,265	3.38	4,420	3.95	311	15.09	209	16.15
American Indian	127	0.34	375	0.34	3	0.15	3	0.23
Asian/ Pacific Islander	[illegible]	6.50	9,325	8.35	96	4.66	10	0.77
Hispanic	32,109	85.90	90,234	80.78	1,476	71.65	626	48.38
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	8	0.39	393	30.37
White	1,451	3.88	7,354	6.58	166	8.06	53	4.10
Total	**37,381**	**100.00**	**111,708**	**100.00**	**2,060**	**100.00**	**1,294**	**100.00**

Children Ages 0 - 15 years	Children 0 - 5 years Living At or Below 200 % Poverty Level[1]		Children 6 - 15 years Living At or Below 200 % Poverty Level[1]		Children involved with DCFS[2]		Children/Youth involved with Juvenile Justice who received Psychotropic medications[3]	
SA	*N*	*%*	N	*%*	*N*	*%*	*N*	*%*
[redacted]								
African American	778	14.60	2,887	10.09	122	30.58	59	26.70
American Indian	54	1.01	110	0.39	2	0.50	0	0.00
Asian/Pacific Islander	409	7.68	6,296	22.01	18	4.51	1	0.45
Hispanic	2,861	53.70	9,529	33.31	155	38.85	87	39.37
Other	0	0.00	0	0.00	0	0	0	0.00
Unknown	0	0.00	0	0.00	13	3.26	41	18.55
White	1,226	23.01	9,784	34.20	89	22.30	33	14.93
Total	**5,328**	**100.00**	**28,606**	**100.00**	**399**	**100.00**	**221**	**100.00**
[redacted]								
African American	11,812	23.21	38,689	25.62	3,943	61.78	1,124	43.21
American Indian	67	0.13	239	0.16	11	0.17	0	0.00
Asian/Pacific Islander	166	0.33	1,938	1.28	44	0.69	8	0.31
Hispanic	38,785	76.20	106,813	70.74	2,177	34.11	757	29.10
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	24	0.38	694	26.69
White	66	0.13	3,309	2.20	183	2.87	18	0.69
Total	**50,896**	**100.00**	**150,988**	**100.00**	**6,382**	**100.00**	**2,601**	**100.00**

Children Ages 0 - 15 years	Children 0 - 5 years Living At or Below 200% Poverty Level[1]		Children 6 - 15 years Living At or Below 200% Poverty Level[1]		Children Involved with DCFS[2]		Children/Youth Involved with Juvenile Justice who received Psychotropic medications[3]	
SA	*N*	*%*	N	*%*	*N*	*%*	*N*	*%*
[redacted]								
African American	931	2.80	3,796	3.90	285	7.74	136	9.94
American Indian	178	0.54	463	0.47	15	0.41	9	0.66
Asian/Pacific Islander	942	2.84	3,778	3.88	84	2.28	15	1.10
Hispanic	30,206	91.01	85,231	87.42	2,900	78.78	729	53.29
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	12	0.33	392	28.65
White	933	2.81	4,225	4.33	385	10.46	87	6.36
Total	**33,190**	**100.00**	**97,493**	**100.00**	**3,681**	**100.00**	**1,368**	**100.00**
[redacted]								
African American	8,889	22.17	28,888	24.00	2,163	46.06	602	33.13
American Indian	189	0.47	503	0.42	22	0.47	9	0.50
Asian/Pacific Islander	3,226	8.04	12,466	10.35	271	5.77	77	4.24
Hispanic	26,318	65.62	71,205	59.16	1,573	33.50	587	32.31
Other	0	0.00	0	0.00	0.00	0.00	0	0.00
Unknown	0	0.00	0	0.00	14	0.29	400	22.00
White	1,482	3.70	7,301	6.07	653	13.91	142	7.82
Total	**40,104**	**100.00**	**120,363**	**100.00**	**4,696**	**100.00**	**1,817**	**100.00**

TRANSITION AGE YOUTH (TAY) 16-25

The priority issues for this age group identified by the Stakeholders include:

- Young people involved in child welfare and probation systems because of mental health issues.
- The lack of supports and services for these youth as they transition out of these systems.
- Invisibility. Many transition age youth who suffer from mental health issues are highly transient and thus present challenges for developing trusting relationships that can lead to effective services and supports being provided.
- Transition age youth and their families who suffer from co-occurring disorders, particularly substance abuse disorders.
- Transition Age Youth who are homeless, and who lack safe, affordable permanent housing.
- Frequent lack of family engagement in issues affecting TAY.
- Lack of culturally aware and competent services and supports.

As with children, very little specific data exists to document patterns of racial, ethnic, and geographic disparities within these specific issues. As proxies, we analyzed transition age youth (ages 16-25) using the data available for the following subgroups: (1) ethnic populations living in poverty, (2) youths who had been involved with the foster care system and the juvenile justice system with at least one crisis episode of mental health care and no prior or follow-up treatment, and (3) youths who were living at 100% or less of the federal poverty guidelines as a proxy for at risk of homelessness.

Disparities among TAY within Poverty and Uninsured Populations

- In 2003, 1,466,904 transition age youth (ages 16-25) lived in the County. The gender and ethnic composition of this population was as follows:

TAY IN GENERAL POPULATION BY GENDER		
Female	721,104	49.16%
Male	745,800	50.84%
Total	**1,466,904**	**100.00%**

TAY IN GENERAL POPULATION BY ETHNICITY		
African-American	139,670	9.52%
American Indian	4,245	0.29%
Asian/Pacific Islander	197,345	13.45%
Hispanic	797,987	54.40%
White	327,657	22.34%
Total	**1,466,904**	**100.00%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Of these TAY, 612,288 lived at or below 200% of federal poverty guidelines. The gender and ethnic composition of this group was as follows:

TAY IN POVERTY BY GENDER		
Female	329,996	53.90%
Male	282,292	46.10%
Total	**612,288**	**100.00%**

TAY IN POVERTY BY ETHNICITY	N	% of Poverty Population	% of Total Ethnic Pop (Previous Table)
African-American	69,501	11.35%	49.76%
American Indian	1,792	0.29%	42.21%
Asian/Pacific Islander	72,276	11.80%	36.62%
Hispanic	388,826	63.50%	48.72%
White	79,893	13.05%	24.38%
Total	**612,288**	**100.00%**	

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- The geographic distribution of this poverty population was as follows:

TAY IN POVERTY BY SERVICE AREA OF RESIDENCE		
1 - Antelope Valley	18,680	3.05%
2 - San Fernando/Santa Clarita Valley	98,167	16.03%
3 - San Gabriel Valley	93,565	15.28%
4 - Metro	90,990	14.86%
5 - West	37,651	6.15%
6 - South	111,522	18.21%
7 - East	73,447	12.00%
8 - South Bay	88,266	14.42%
Total	**612,288**	**100.00%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Data for uninsured households is much less precise. We have countywide ethnicity data, and data by Service Area, but not data by ethnicity by Service Area. The data we do have reveal the following patterns:

UNINSURED TAY BY GENDER		
Female	146,000	41.36%
Male	206,000	58.36%
Unknown	1,000	0.28%
Total	**353,000**	**100.00%**

UNINSURED TAY 16-25 BY ETHNICITY		
Latino	224,000	63.46%
American Indian/Alaska Native	1,000	0.28%
Asian	30,000	8.50%
African American	20,000	5.67%
White	62,000	17.56%
Other single/2 or more races	15,000	4.25%
Unknown	1,000	0.28%
Total	**353,000**	**100.00%**

UNINSURED TAY 16-25 BY SERVICE AREA OF RESIDENCE		
1 - Antelope Valley	8,000	2.27%
2 - San Fernando/Santa Clarita Valley	67,000	18.98%
3 - San Gabriel Valley	54,000	15.30%
4 - Metro	54,000	15.30%
5 - West	22,000	6.23%
6 - South	41,000	11.61%
7 - East	49,000	13.88%
8 - South Bay	58,000	16.43%
Total	**353,000**	**100.00%**

Source: UCLA, 2003 California Health Interview Survey (CHIS)

- This data reveals several patterns beyond those discussed in the Children's population, including:
  - While African American and Hispanic TAY are still significant portions of the poverty and uninsured populations, Asian and Pacific Islander (API) transition age *youth* are a much greater percentage of all TAY living in poverty than are API *children*.
  - The percentage of male uninsured TAY is significantly higher than their percentage in the general or poverty populations.
  - Relatively more TAY are poor and uninsured than are children.

Involvement with DCFS

- Countywide in FY 2002-03, 3,248 TAY over 18 years of age were clients of the Department of Children and Family Services (DCFS). Note the age range for this analysis is over 18 rather than 16-25. Current data sources do not permit a more precise analysis for TAY 16-25.
- Of the 3,248 children TAY over 18 who were DCFS clients:
  - 295 were in D-Rate facilities. Of these young people, 52.2% received some DMH service during the FY 2002-03.
  - 1,088 (33.40%) TAY received at least one mental health service from DMH during the FY 2002-03. An additional 736 of the young people involved with DCFS received mental health services from DMH prior to FY2002-03.
- There are significant geographic disparities. Of the total DCFS population, Service Area 6 (Central Los Angeles) had the highest number of transition age youths (1,345), and the highest concentration of poverty within this age group, both significantly disproportionate to the population size for that Service Area.

Involvement with Probation

- Countywide, 9,621 youths were involved with Probation and treated by DMH. Most of the youths (83.19%) were male and 3,677 of the total were Hispanic (38.22%). In many cases (27.14%), the ethnicity was unknown or not reported.

At risk of Homelessness

The Homeless Count data for Los Angeles County has just become available; we have not had sufficient time to analyze the results of this effort. This data, however, will not help us estimate numbers of transition age youth at risk of homelessness. For this factor, we used the incidence of TAY with income at or less than 100% of the Federal poverty guidelines as a first proxy for at-risk of homelessness for transition age youths.

This data reveals:

- Hispanic youth comprise 63.12% of the total TAY population with income at or less than 100% of the Federal poverty guidelines and therefore at risk of homelessness. The comparable percentage for adults is approximately 55%.
- African American youth comprise 12.48% of the total TAY population at risk for homelessness; Asian and Pacific Islander youth 12.45%; and White youth 11.6%.

Other Community Issues and Data Sources

The other community issues of significant concern to the stakeholders included: (1) invisibility of transition age youths suffering from serious mental health issues; (2) transition age youths and their families who suffer from co-occurring disorders, particularly substance abuse; (3) lack of safe, affordable, permanent housing; children of parents with SMI or co-occurring disorders; (4) frequent lack of family engagement with issues affecting transition age youth; and (5) lack of culturally aware and competent services and supports. At the current time, however, we lack reliable data sources for further analysis.

The Stakeholders have substantial experiential data about how these issues cause significant disruption to the healthy development of TAY within our county. Stakeholders have made the creation of new data sources and the strengthening of existing data for addressing these issues a high priority for the next 3 years.

The following tables present more detailed data by Service Area to further support the analysis above. Note that some of the data sources by Service Area use different age ranges, creating some anomalies between the Countywide and Service Area analysis. While the totals vary somewhat, the patterns described above remain consistent.

Notes on Table Sources for TAY (ages 16-25 unless otherwise specified)
Focal Population Proxies analyzed by Age Group, Service Area, and Ethnicity

[a] (CPI-U) We are using the 100% poverty level as an indicator that this population is at most risk of becoming homelessness. Measure of Need is based on Poverty thresholds that are the dollar amounts used to determine poverty status.

[b] DCFS. These are clients **not** seen by DMH.

[c] LAC Planning File UOS FY 2002-2003.

Transitional Age Youth (ages 16-25)	At Risk of Homelessness (200% Poverty Level)[3]		Ever in 16-25 Investigation DCFS[4]		Involvement with Juvenile Justice with at least one crisis episode and no prior or follow up treatment[5]	
Service Area (SA)	N	%	N	%	N	%
[redacted]						
African American	2,011	24%	284	52%	14	44%
American Indian	89	1%	0	0%	0	0%
Asian/Pacific Islander	291	3%	4	1%	0	0%
Latino	3,154	38%	119	22%	6	19%
White	2,797	34%	133	25%	5	16%
Other	0	0%	2	0%	0	0%
Unknown or Not Reported	0	0%	0	0%	7	22%
Total	**8,342**	**100%**	**542**	**100%**	**32**	**100%**
[redacted]						
African American	1,948	5%	128	22%	13	10%
American Indian	142	0%	5	1%	0	0%
Asian/Pacific Islander	3,471	9%	16	3%	3	2%
Latino	22,617	61%	278	49%	68	54%
White	9,150	25%	141	25%	17	13%
Other	0	0%	1	0%	1	0%
Unknown or Not Reported	0	0%	0	0%	25	20%
Total	**37,328**	**100%**	**569**	**100%**	**127**	**100%**
[redacted]						
African American	2,389	6%	305	31%	28	9%
American Indian	143	0%	6	1%	1	0%
Asian/Pacific Islander	11,216	27%	45	5%	9	3%
Latino	21,475	57%	495	50%	157	49%
White	3,763	10%	143	14%	18	6%
Other	0	0%	3	0%	1	0%
Unknown or Not Reported	0	0%	0	0%	105	33%
Total	**37,995**	**100%**	**997**	**100%**	**319**	**100%**

Transitional Age Youth ages 16-25	TAY at Risk of Homelessness (138% Poverty Level)[3]		TAY 16-25 Involved in DCFS[4]		TAY Involved with Juvenile Justice with at least one crisis episode and no prior or follow up treatment[5]	
Service Area (SA)	N	%	N	%	N	%
[redacted]						
African American	1,412	4%	119	31%	6	10%
American Indian	94	0%	1	0%	0	0%
Asian/Pacific Islander	4,611	13%	16	4%	0	0%
Latino	27,413	76%	221	58%	25	43%
White	2,434	7%	26	7%	3	5%
Other	0	0%	1	0%	0	0%
Unknown or Not Reported	0	0%	0	0%	24	41%
Total	**36,041**	**100%**	**384**	**100%**	**58**	**100%**
[redacted]						
African American	846	8%	33	41%	2	18%
American Indian	21	0%	1	1%	0	0%
Asian/Pacific Islander	2,916	28%	2	2%	0	0%
Latino	3,131	30%	24	30%	5	45%
White	3,595	34%	19	23%	1	9%
Other	0	0%	2	2%	0	0%
Unknown or Not Reported	0	0%	0	0%	3	27%
Total	**10,488**	**100%**	**81**	**100%**	**11**	**100%**
[redacted]						
African American	12,564	27%	1,006	75%	207	32%
American Indian	52	0%	1	0%	0	0%
Asian/Pacific Islander	1,011	2%	7	1%	1	0%
Latino	30,920	67%	289	21%	214	33%
White	1,332	3%	38	3%	0	0%
Other	0	0%	4	0%	0	0%
Unknown or Not Reported	0	0%	0	0%	223	35%
Total	**45,877**	**100%**	**1,345**	**100%**	**645**	**100%**

Transitional Age Youth ages 16-25	TAY at Risk of Homelessness (<100% Poverty Level)[1]		TAY 16-25 Involved in DCFS[2]		TAY Involved with Juvenile Justice with at least one crisis episode and no prior or follow up treatment[3]	
Service Area	N	%	N	%	N	%
[redacted]						
African American	1,077	4%	82	14%	28	7%
American Indian	152	1%	1	0%	2	0%
Asian/Pacific Islander	1,611	6%	12	2%	3	1%
Latino	25,113	83%	428	71%	204	50%
White	2,014	7%	77	13%	20	5%
Other	0	0%	1	0%	2	0%
Unknown or Not Reported	0	0%	0	0%	153	37%
Total	**30,294**	**100%**	**601**	**100%**	**412**	**100%**
[redacted]						
African American	8,039	22%	550	62%	107	23%
American Indian	154	0%	8	1%	4	1%
Asian/Pacific Islander	5,711	16%	40	5%	19	4%
Latino	19,421	53%	175	20%	146	32%
White	3,090	8%	114	13%	29	6%
Other	0	0%	0	0%	3	1%
Unknown or Not Reported	0	0%	0	0%	151	33%
Total	**36,405**	**100%**	**887**	**100%**	**459**	**100%**

ADULTS 26-59

The priority issues for this age group identified by the Stakeholders include:

- The frequent cycle suffered by many adults struggling with mental health issues that sees people cycle between homelessness, institutionalization, incarceration, and emergency rooms.
- Co-occurring disorders, particularly substance abuse disorders.
- Lack of adequate transition facilities to help people move out of institutional settings and into more community based settings.
- Adults who are homeless, and who lack safe, affordable, permanent housing.
- A general lack of awareness and acceptance of mental health issues.
- Lack of culturally aware and competent services and supports.

As with the other age groups, very little specific data exists to document patterns of racial, ethnic, and geographic disparities within these specific issues. As proxies, we analyzed adults (ages 26-59) using the data available for the following subgroups: (1) adults who are living in poverty; (2) adults who are at risk for homelessness; and (3) adults with 6 or more hospitalizations within a 12-month period who are cycling among public systems, including the criminal justice system, with at least one mental health service episode.

Disparities among Adults within Poverty and Uninsured Populations

- In FY 2002-03, 4,582,527 adults (ages 26-59) lived in the County. The gender and ethnic composition of this population was as follows:

ADULTS IN GENERAL POPULATION BY GENDER		
Female	2,315,041	50.52%
Male	2,267,486	49.48%
Total	**4,582,527**	**100.00%**

ADULTS IN GENERAL POPULATION BY ETHNICITY		
African-American	437,516	9.55%
American Indian	15,481	0.34%
Asian/Pacific Islander	672,267	14.67%
Hispanic	1,973,668	43.07%
White	1,483,595	32.38%
Total	**1,466,904**	**100.00%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Of these adults, 1,735,831 lived at or below 200% of federal poverty guidelines. The gender and ethnic composition of this group was as follows:

ADULTS IN POVERTY BY GENDER			
Female		950,880	55.00%
Male		784,951	45.00%
	Total	**1,735,831**	**100.00%**

ADULTS IN POVERTY BY ETHNICITY			
	N	**% of Poverty Population**	**% of Total Ethnic Pop (Previous Table)**
African-American	214,789	12.37%	49.09%
American Indian	7,464	0.43%	48.21%
Asian/Pacific Islander	208,005	11.98%	30.94%
Hispanic	1,005,712	57.94%	50.95%
White	299,861	17.27%	20.21%
Total	**1,735,831**	**100.00%**	

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- The geographic distribution of this poverty population was as follows:

ADULTS IN POVERTY BY SERVICE AREA OF RESIDENCE			
1 - Antelope Valley		47,705	2.75%
2 - San Fernando/Santa Clarita Valley		306,944	17.68%
3 - San Gabriel Valley		258,341	14.88%
4 - Metro		312,527	18.00%
5 - West		90,564	5.22%
6 - South		261,826	15.08%
7 - East		204,166	11.76%
8 - South Bay		253,758	14.62%
	Total	**1,735,831**	**100.00%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Data for uninsured households is much less precise. We have countywide ethnicity data, and data by Service Area, but not data by ethnicity by Service Area. The data we do have reveal the following patterns:

UNINSURED ADULTS BY GENDER			
Female		513,000	47.90%
Male		558,000	52.10%
	Total	**353,000**	**100.00%**

UNINSURED ADULTS BY ETHNICITY		
Latino	678,000	63.31%
American Indian/Alaska Native	7,000	0.65%
Asian	93,000	8.68%
African American	74,000	6.91%
White	185,000	17.27%
Other single/2 or more races	33,000	3.08%
Unknown	1,000	0.09%
Total	**1,071,000**	**100.00%**

UNINSURED ADULTS BY SERVICE AREA OF RESIDENCE		
1 - Antelope Valley	20,000	1.87%
2 - San Fernando/Santa Clarita Valley	181,000	16.90%
3 - San Gabriel Valley	187,000	17.46%
4 - Metro	191,000	17.83%
5 - West	68,000	6.35%
6 - South	127,000	11.86%
7 - East	130,000	12.14%
8 - South Bay	166,000	15.50%
Unknown SA	1,000	0.09%
Total	**1,071,000**	**100.00%**

Source: UCLA, 2003 California Health Interview Survey (CHIS)

- This data reveals:
  - In 2003, of 4,582,527 adults who resided in the County, slightly over one third (38%) were part of households with income at or below the 200% poverty level.
  - Of 437,516 African American adults who resided in the County, 214,789 (49.09%) adults lived in households with income at or below the 200% poverty level and, of this group, 74,000 (34.45%) were uninsured. (Note our assumption that people who are uninsured are people within the poverty population.)
  - Of 15,481 American Indian adults who resided in the County, 7,464 (48.20%) lived in households with income at or below the 200% poverty level and, of this group, 7,000 (93.70%) adults were uninsured.
  - Of 672,267 Asian adults who resided in the County, 208,005 (30.90%) lived in households with income at or below the 200% poverty level and, of this group, 93,000 (44.70%) adults were uninsured.

- Of 1,973,668 Hispanic adults who resided in the County, 1,005,712 (50.9%) lived in households with income at or below the 200% poverty level and, of this group, 678,000 (67.40%) adults were uninsured.
- Of 1,483,595 White adults who resided in the County, 299,861 (20.2%) lived in households with income at or below the 200% poverty level and, of this group, 185,000 (61.60%) were uninsured.

Lack of Safe, Affordable, Permanent Housing

The stakeholders determined that certain types of available risk indicators may be relevant to deepening our analysis of certain populations. For example, they determined that the incidence of households with income at or less than 100% of the Federal poverty level for adults may be relevant to understanding the risk of homelessness for adults.

- In 2003, of all the adults residing in Los Angeles County, 637,863 (13.90%) adults lived in households with income less than 100% of the poverty level.
- Among Hispanic adults, representing 43% of the overall county population, 356,586 adults (55.90%) were at risk of homelessness.
- Among White adults, representing 32.38% of the overall county population, 108,290 (6.9%) adults were at risk of homelessness.
- Among all other ethnic subgroups, the risk of homelessness was approximately equivalent to their ethnic representation within the overall population.

Adults Cycling Through Public Systems

Information systems available to DMH by other county agencies may provide avenues in the future for collecting data about the manner in which adults cycle among homelessness, institutionalization, incarceration, and emergency rooms.

For now, however, we are able to provide rates of re-hospitalization within the adult population. For example:

- During FY 2002-2003, over 350 adults were hospitalized six or more times, excluding State hospitals, but including private Medi-Cal hospitals and County hospitals.
- The currently available data suggests that these cases were concentrated among Whites, except in Service Area 6 and Service Area 8, where the re-hospitalization rates were concentrated among African Americans.

Other Community Issues and Data Sources

The other community issues of significant concern to the stakeholders included: (1) co-occurring disorders, particularly substance abuse; (2) lack of adequate transition facilities; (3) lack of awareness and acceptance of mental health issues; and (4) lack of culturally aware and competent services and supports. Section V details analysis of the systems capacity to deliver culturally appropriate and sensitive services. At the current time, we lack reliable data sources for further analysis of the other issues.

The Stakeholders have substantial experiential data about how these issues cause significantly impact the recovery and wellness of adults within our county. DMH and the

Stakeholders have made the creation of new data sources and the strengthening of existing data to address these issues a high priority.

The following tables present more detailed data by Service Area to further support the analysis above. Note that some of the data sources by Service Area use different age ranges, creating some anomalies between the Countywide and Service Area analysis. While the totals vary somewhat, the patterns described above remain consistent.

Notes on Table Sources for Adults (ages 26-59 unless otherwise specified)
Focal Population Proxies analyzed by Age Group, Service Area, and Ethnicity

[a] *Hedderson, J. & Bixler, J., Walter R. McDonald & Associates, Inc. Sacramento, CA.* Countywide poverty population estimates published during the MHSA stakeholder process do not vary; however, when the estimates are broken into small categories, such as SPA and ethnicity or into even smaller sub-categories such as ethnicity within SPA, the sub-total (category totals) typically vary. This variance is not statistically significant.

[b] *Urban Research, Service Integration Branch, Los Angeles, CA*. Includes individuals living at the 100% Poverty Level in Los Angeles County as of July 1, 2004.

[c] *LAC-DMH Planning Files, FY 2002 – 2003*. Excludes State Hospitals, with Mode 05 / SFC 10 – 20

[d] *LAC-DMH Planning Files, FY 2002 – 2003*.

Adults Ages 26-59 years	Adults Living in Poverty (At or Below 200% Poverty Level)[a]		Adults at risk of homelessness (at 200% Poverty Level)[b]		Adults with 3 or more hospitalizations within a 12-month period[c]		Adults involved with the criminal justice system w/ at least one MH Episode[d]	
Service Planning Area (SA)	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
[redacted]								
African American	11,540	24.19	3,171	20.38	2	50.00	365	44.24
American Indian	631	1.32	219	1.41	0	0.00	1	0.12
Asian/ Pacific Islander	1,433	3.01	618	3.97	0	0.00	3	0.36
Hispanic	17,346	36.36	5,492	35.30	0	0.00	95	11.52
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00	24	2.91
White	16,753	35.12	6,058	38.94	2	50.00	337	40.85
Total	**47,705**	**100.00**	**15,558**	**100.00**	**4**	**100.00**	**825**	**100.00**
[redacted]								
African American	17,697	5.77	5,772	5.37	7	17.07	396	17.98
American Indian	1,579	0.51	560	0.52	0	0.00	6	0.27
Asian/ Pacific Islander	26,373	8.59	11,812	10.99	3	7.32	16	0.73
Hispanic	162,914	53.08	55,386	51.51	2	4.88	484	21.98
Other	0	0.00	0	0.00	0	0.00	1	0.05
Unknown	0	0.00	0	0.00	1	2.44	104	4.72
White	98,379	32.05	33,989	31.61	28	68.29	1,195	54.27
Total	**306,944**	**100.00**	**107,519**	**100.00**	**41**	**100.00**	**2,202**	**100.00**

Adults Ages 26-59 years	Adults Living in Poverty (100% and below)[1]		Adults at risk of homelessness (100% Poverty Level)[1]		Adults with 6 or more hospitalizations within a 12-month period[2]		Adults involved with the criminal justice system w/ at least one MH Episode[3]	
SA	N	%	N	%	N	%	N	%
[redacted]								
African American	14,657	5.67	5,097	5.32	13	34.21	508	25.43
American Indian	1,211	0.47	411	0.43	0	0.00	9	0.45
Asian/Pacific Islander	74,778	28.95	31,898	33.32	2	5.26	19	0.95
Hispanic	133,944	51.85	45,838	47.88	9	23.68	711	35.59
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	1	2.63	90	4.50
White	33,751	13.06	12,493	13.05	13	34.21	661	33.08
Total	**258,341**	**100.00**	**95,737**	**100.00**	**38**	**100.00**	**1,998**	**100.00**
[redacted]								
African American	21,959	7.03	7,071	5.82	48	43.24	1,629	38.02
American Indian	947	0.30	350	0.29	0	0.00	10	0.23
Asian/Pacific Islander	45,114	14.41	21,620	17.78	1	0.90	41	0.96
Hispanic	195,497	62.55	75,552	62.13	7	6.31	825	19.25
Other	0	0.00	0	0.00	0	0.00	1	0.02
Unknown	0	0.00	0	0.00	2	1.80	789	18.41
White	49,100	15.71	17,001	13.98	53	47.75	990	23.10
Total	**312,527**	**100.00**	**121,594**	**100.00**	**111**	**100.00**	**4,285**	**100.00**

Adults Ages 18-59 years	Adults Living in Poverty (200% Ward Value)[1]		Adults at risk of homelessness (100% Poverty Level)[1]		Adults with 6 or more hospitalizations within a 12-month period[1]		Adults involved with the criminal justice system w/ at least one MH Episode[1]	
SA	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
[redacted]								
African American	8,619	9.52	2,901	7.93	9	42.86	237	30.82
American Indian	403	0.44	145	0.40	0	0.00	3	0.39
Asian/ Pacific Islander	14,953	16.51	8,621	23.57	0	0.00	9	1.17
Hispanic	22,978	25.37	8,688	23.75	1	4.76	108	14.04
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	1	4.76	25	3.25
White	43,611	48.15	16,226	44.36	10	47.62	387	50.33
Total	**90,564**	**100.00**	**36,581**	**100.00**	**21**	**100.00**	**769**	**100.00**
[redacted]								
African American	77,347	29.54	28,938	29.94	42	64.62	3,458	81.98
American Indian	258	0.10	85	0.09	0	0.00	7	0.17
Asian/ Pacific Islander	3,107	1.18	2,112	2.18	0	0.00	5	0.12
Hispanic	178,891	68.32	63,970	66.18	5	7.69	471	11.17
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00	94	2.23
White	2,243	0.86	1,559	1.61	18	27.69	183	4.34
Total	**261,826**	**100.00**	**96,664**	**100.00**	**65**	**100.00**	**4,218**	**100.00**

Adult Ages 26-59 years	Adults Living in Poverty (200% Federal Poverty Level)[1]		Adults at risk of homelessness (100% Poverty Level)[2]		Adults with 8 or more hospitalizations within a 12-month period[3]		Adults involved with the criminal justice system w/ at least one SMI Episode[4]	
SA	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
[redacted]								
African American	6,844	3.35	2,017	2.82	3	10.34	181	11.44
American Indian	1,104	0.54	362	0.51	0	0.00	6	0.38
Asian/ Pacific Islander	12,633	6.19	5,519	7.71	1	3.45	8	0.51
Hispanic	167,356	81.97	57,421	80.26	8	27.59	853	53.92
Other	0	0.00	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00	79	4.99
White	16,229	7.95	6,228	8.70	17	58.62	455	28.76
Total	**204,166**	**100.00**	**71,547**	**100.00**	**29**	**100.00**	**1,582**	**100.00**
[redacted]								
African American	56,126	22.12	18,992	20.50	35	44.87	1,672	48.86
American Indian	1,331	0.52	468	0.51	0	0.00	10	0.29
Asian/ Pacific Islander	29,721	11.71	14,228	15.35	1	1.28	42	1.23
Hispanic	126,786	49.96	44,239	47.74	6	7.69	511	14.93
Other	0	0.00	0	0.00	1	1.28	0	0.00
Unknown	0	0.00	0	0.00	2	2.56	119	3.48
White	39,795	15.68	14,736	15.90	33	42.31	1,068	31.21
Total	**253,758**	**100.00**	**92,663**	**100.00**	**78**	**100.00**	**3,422**	**100.00**

OLDER ADULTS

The priority issues for this age group include:

- Lack of understanding and commitment for addressing mental health issues among the older adult population from policymakers, clinicians, community leaders, and others.
- Significant differences in needs and issues affecting younger older adults (60—65) and adults older than 65.
- Lack of basic resources and infrastructure for a system of care for older adults.
- Lack of effective data documenting the needs of this population.
- Multiple barriers to accessing services—e.g., providing effective services to people who are homebound.
- Lack of culturally aware and competent services and supports.

As with the other age groups, very little specific data exists to document patterns of racial, ethnic, and geographic disparities within these specific issues. As proxies, we analyzed older adults (ages 60+) using the data available for the following subgroups: older adults who are living in poverty and who are uninsured; older adults with 6 or more hospitalizations within a 12-month period; and older adults who are involved with ACT or AB 2034 programs. We should note that there have been particular concerns about the data related to older adults, particularly prevalence data but other demographic data as well. Stakeholders have made a commitment to re-examine the overall data for this population in the coming year.

Disparities among Older Adults within Poverty and Uninsured Populations

- In FY 2002-03, 1,437,681 older adults lived in the County. The gender and ethnic composition of this population was as follows:

OLDER ADULTS IN GENERAL POPULATION BY GENDER		
Female	819,584	57.01%
Male	618,097	42.99%
Total	**1,437,681**	**100.00%**

OLDER ADULTS IN GENERAL POPULATION BY ETHNICITY		
African-American	144,878	10.08%
American Indian	4,062	0.28%
Asian/Pacific Islander	210,189	14.62%
Hispanic	328,977	22.88%
White	749,575	52.14%
Total	**1,437,681**	**100.00%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Of these older adults, 490,537 lived at or below 200% of federal poverty guidelines. The gender and ethnic composition of this group was as follows:

OLDER ADULTS IN POVERTY BY GENDER		
Female	318,665	64.96%
Male	171,872	35.04%
Total	**490,537**	**100.00%**

OLDER ADULTS IN POVERTY BY ETHNICITY			
	N	**% of Poverty Population**	**% of Total Ethnic Pop (Previous Table)**
African-American	74,091	15.10%	52.14%
American Indian	876	0.18%	21.56%
Asian/Pacific Islander	78,807	16.07%	37.49%
Hispanic	159,058	32.43%	48.35%
White	177,705	36.23%	23.70%
Total	**490,537**	100.00%	

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- The geographic distribution of this poverty population was as follows:

OLDER ADULTS IN POVERTY BY SERVICE AREA OF RESIDENCE		
1 - Antelope Valley	11,627	2.37%
2 - San Fernando/Santa Clarita Valley	94,370	19.24%
3 - San Gabriel Valley	86,536	17.64%
4 - Metro	82,743	16.87%
5 - West	30,692	6.26%
6 - South	61,729	12.58%
7 - East	56,318	11.48%
8 - South Bay	66,522	13.56%
Total	**490,537**	**100.00%**

Source: John Hedderson and Joyce Bixler, Walter R. McDonald & Associates, Inc. Sacramento, CA for County of Los Angeles, CA

- Data for uninsured households is much less precise. We have countywide ethnicity data, and data by Service Area, but not data by ethnicity by Service Area. The data we do have reveal the following patterns:

UNINSURED OLDER ADULTS BY GENDER		
Female	32,000	61.54%
Male	19,000	36.54%
Total	**1,071,000**	**100.00%**

UNINSURED OLDER ADULTS BY ETHNICITY		
Latino	678,000	63.31%
American Indian/Alaska Native	7,000	0.65%
Asian	93,000	8.68%
African American	74,000	6.91%
White	185,000	17.27%
Other single/2 or more races	33,000	3.08%
Unknown	1,000	0.09%
Total	**1,071,000**	**100.00%**

UNINSURED OLDER ADULTS BY SERVICE AREA OF RESIDENCE		
1 - Antelope Valley	20,000	1.87%
2 - San Fernando/Santa Clarita Valley	181,000	16.90%
3 - San Gabriel Valley	187,000	17.46%
4 - Metro	191,000	17.83%
5 - West	68,000	6.35%
6 - South	127,000	11.86%
7 - East	130,000	12.14%
8 - South Bay	166,000	15.50%
Unknown SA	1,000	0.09%
Total	**1,071,000**	**100.00%**

Source: UCLA, 2003 California Health Interview Survey (CHIS)

- This data reveals:
  - In 2003, of the 1,437,681 older adults who resided in the County, 490,537 (34.10%) lived with income at or below 200% of the poverty level.
  - Of 144,878 African American older adults who resided in the County, 74,091 (51.10%) lived in households with income at or below the 200% poverty level and, of this group, 5,000 (6.70%) were uninsured. Note again our assumption that an uninsured family was also at or below the 200% poverty guideline.
  - Of 4,062 older American Indians who resided in the County, 876 (25.10%) lived in households with income at or below the 200% poverty level. Interestingly, no one within this group was identified as uninsured (most likely a limitation of the data).
  - Of 210,189 older Asian Americans who resided in the County, 78,807 (37.40%) lived in households with income at or below the 200% poverty level and, of this group, 9,000 (11.40%) were uninsured.
  - Of 328,977 older Hispanic adults who resided in the County, 159,058 (48.30%) lived in households with income at or below the 200% poverty level and, of this group, 22,000 (13.80%) were uninsured.

- Of 749,575 older White adults living in the County, 177,705 (23.70%) lived in households with income at or below the 200% poverty level and, of this group, 12,000 (6.7%) older adults were uninsured.
- Significant patterns related to gender become obvious from this data. Women are significantly larger percentages of all of the tracked populations for this age group than in previous age groups.

A central limitation of this data: The insurance needs for older adults are likely more severe than for other age groups, and more invisible. For example, Medicare is counted as health insurance, but the coverage for mental illness or related conditions may be completely inadequate or absent.

Other Community Issues and Data Sources

The other community issues of significant concern to the stakeholders included: (1) lack of understanding and commitment for addressing mental health issues among older adult population from policymakers, clinicians, community leaders, and others; (2) significant differences in needs and issues affecting younger older adults and older older adults; (3) lack of basic resources and infrastructure for a system of care for older adults; (4) lack of effective data for documenting the needs of older adults; (5) addressing multiple barriers to accessing services; and (5) lack of culturally aware and competent services and supports. Section V details analysis of the systems capacity to deliver culturally appropriate and sensitive services. At the current time, we lack reliable data sources for more extensive analysis of the other issues.

The Stakeholders nevertheless have substantial experiential data about how these issues affect the prospects for recovery and wellness for older adults within our county. DMH and the stakeholders have made the creation of new data sources and the strengthening of existing data to address these issues a high priority.

The following tables present more detailed data by Service Area to further support the analysis above.

Notes on Table Sources for Older Adults (ages 60+ unless otherwise specified)
Focal Population Proxies analyzed by Age Group, Service Area, and Ethnicity

[a] *Hedderson, J. & Bixler, J., Walter R. McDonald & Associates, Inc. Sacramento, CA.* Countywide poverty population estimates published during the MHSA stakeholder process do not vary; however, when the estimates are broken into small categories, such as SPA and ethnicity or into even smaller sub-categories such as ethnicity within SPA, the sub-total (category totals) typically vary. This variance is not statistically significant.

[b] *LAC-DMH Planning Files, FY 2002 – 2003.* Mode 05 / SFC 10 - 20. These hospitalizations exclude State Hospitals.

[c] *LAC-DMH Planning Files, FY 2002 – 2003*. Clients enrolled in an ACT or AB 2034 program with LAC-DMH during FY 2002 – 2003.

Older Adults Ages 60+ years	Older Adults in Poverty (At or Below 200% Poverty Level)[2]		Older Adults with 6 or more hospitalizations within a 12-month period[3]		Older Adults Enrolled in FCT or AB2034 Programs[4]	
Service Planning Area (SA)	*N*	*%*	*N*	*%*	*N*	*%*
[redacted]						
African American	1,972	16.96	0	0.00	0	0.00
American Indian	58	0.50	0	0.00	0	0.00
Asian/Pacific Islander	382	3.29	0	0.00	0	0.00
Hispanic	2,604	22.40	0	0.00	0	0.00
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00
White	6,611	56.86	0	0.00	0	0.00
Total	**11,627**	**100.00**	**0**	**100.00**	**0**	**100.0**
[redacted]						
African American	2,227	2.36	0	0.00	5	20.83
American Indian	156	0.17	0	0.00	0	0.00
Asian/Pacific Islander	8,941	9.47	0	0.00	0	0.00
Hispanic	23,395	24.79	0	0.00	3	12.50
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00
White	59,652	63.21	0	0.00	16	66.67
Total	**94,370**	**94,370**	**0**	**100.00**	**24**	**100.00**

Older Adults Ages 60+ years	Older Adults in Living at or Below 200% Poverty Level[3]		Older Adults with 2 or more Hospitalizations within a 12-month period[3]		Older adults Enrolled in a CSS or MHSA Programs[4]	
SA	*N*	*%*	*N*	*%*	*N*	*%*
[redacted]						
African American	5,357	6.19	1	25.00	1	6.25
American Indian	186	0.21	0	0.00	0	0.00
Asian or Pacific Islander	26,542	30.67	0	0.00	1	6.25
Hispanic	28,282	32.68	1	25.00	3	18.75
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	1	25.00	1	6.25
White	26,169	30.24	1	25.00	10	62.50
Total	**86,536**	**100.00**	**4**	**100.00**	**16**	**100.00**
[redacted]						
African American	5,692	6.88	0	0.00	10	32.26
American Indian	84	0.10	0	0.00	0	0.00
Asian or Pacific Islander	22,784	27.55	0	0.00	1	3.23
Hispanic	31,055	37.53	1	50.00	4	12.90
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00
White	23,118	27.94	1	50.00	16	51.61
Total	**82,743**	**100.00**	**2**	**100.00**	**31**	**100.00**

Older Adults Ages 60+ years	Older Adults in Living At or Below 200% Poverty Level[1]		Older adults with 6 or more hospitalizations within a 12- month period[2]		Older adults Enrolled in ACT or AB2034 Programs[3]	
SA	*N*	*%*	*N*	*%*	*N*	*%*
[redacted]						
African American	1,875	6.11	0	0.00	1	25.00
American Indian	31	0.10	0	0.00	0	0.00
Asian/ Pacific Islander	2,744	8.96	0	0.00	0	0.00
Hispanic	4,457	14.52	0	0.00	1	25.00
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00
White	21,580	70.31	0	0.00	2	50.00
Total	**30,692**	**100.00**	**0**	**100.00**	**4**	**100.00**
[redacted]						
African American	42,007	68.05	2	66.67	15	51.72
American Indian	40	0.06	0	0.00	0	0.00
Asian/ Pacific Islander	1,141	1.85	0	0.00	0	0.00
Hispanic	17,361	28.12	1	33.33	5	17.24
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00
White	1,181	1.91	0	0.00	9	31.03
Total	**61,729**	**100.00**	**3**	**100.00**	**29**	**100.00**

Older adults Ages 60+ years	Older adults in Living At or Below 200% Poverty Level[3]		Older Adults with 3 or more hospitalizations within a 12-month period[4]		Older Adults Enrolled in ACT or AB2034 Programs[5]	
SA	*N*	%	*N*	%	*N*	%
[redacted]						
African American	1,173	2.08	0	0.00	6	28.57
American Indian	155	0.28	1	20.00	0	0.00
Asian/ Pacific Islander	5,587	9.92	0	0.00	0	0.00
Hispanic	34,687	61.59	0	0.00	2	9.52
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	2	9.52
White	14,716	26.13	4	80.00	11	52.39
Total	**56,318**	**100.00**	**5**	**100.00**	**21**	**100.00**
[redacted]						
African American	13,788	20.73	2	40.00	18	24.66
American Indian	166	0.25	0	0.00	0	0.00
Asian/ Pacific Islander	10,673	16.04	0	0.00	0	0.00
Hispanic	17,217	25.88	1	20.00	10	13.70
Other	0	0.00	0	0.00	0	0.00
Unknown	0	0.00	0	0.00	0	0.00
0White	24,678	37.10	2	40.00	45	61.64
Total	**66,522**	**100.00**	**5**	**100.00**	**73**	**100.00**

4) If you selected any community issues that are not identified in the "Direction" section above, please describe why these issues are more significant for your county/community and how the issues are consistent with the purpose and intent of the MHSA.

Not applicable (N/A)

PART II, SECTION II: Analyzing Mental Health Needs in the Community

1) Using the information from population data for the county and any available estimates of unserved populations, provide a narrative analysis of the unserved populations in your county by age group. Specific attention should be paid to racial and ethnic disparities.

Geography and Scale

Los Angeles County spans over 4,018 square miles with a resident population of almost 10 million people. Los Angeles County government uses eight service areas for planning, called Service Areas (SA) or Service Planning Areas (SPA), to help facilitate decentralized planning and service delivery. Demographics, geography, culture, and history vary widely across the eight Service Areas, adding further complexity to any comprehensive planning effort in the County.

While more comprehensive data is available countywide, it is often lacking for specific Service Areas or for communities within Service Areas. We have worked to use what data there is, and are developing an aggressive data development agenda for the coming years.

Poverty

In 2003, 3,516,838 (35.27%) individuals of the total population of 9.9 million individuals in Los Angeles County resided in poverty. Individuals residing in households with incomes at or lower than 200% of the poverty income level were defined as populations living in poverty. Individuals residing in households with incomes at or below 100% of the poverty income level were considered to be at risk of homelessness.

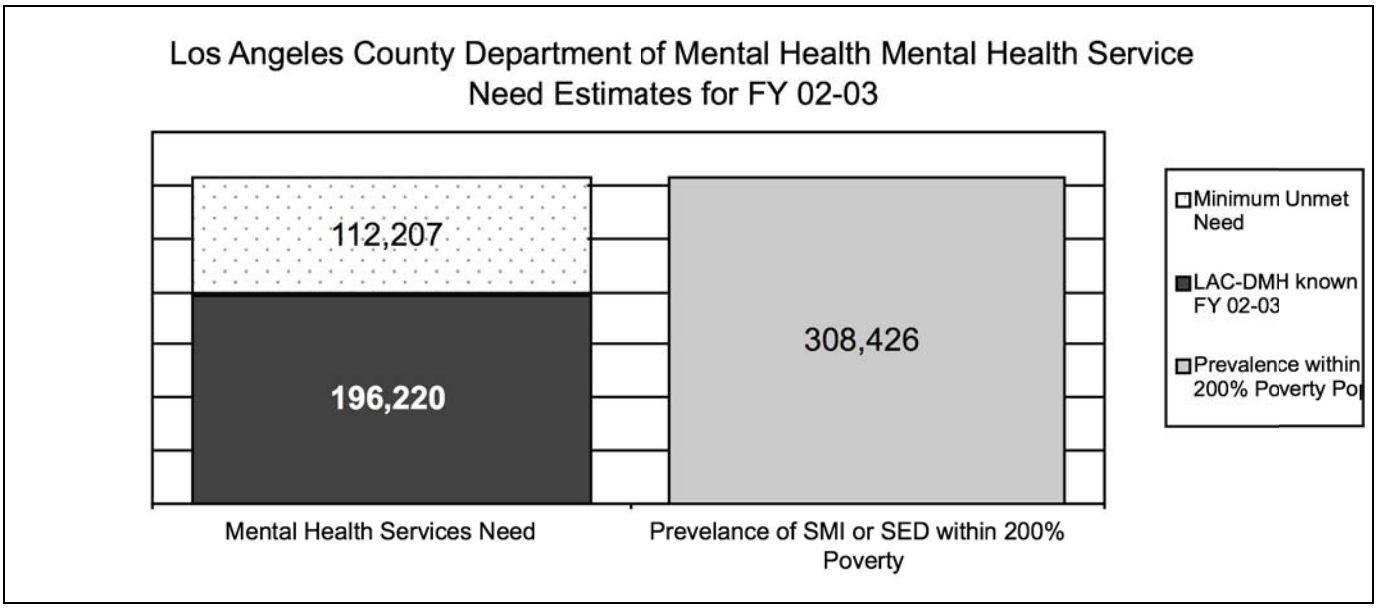
Prevalence

According to the California State Department of Mental Health, the combined prevalence rate of Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI), across all age groups, for those living in poverty within the County is 8.77%. This prevalence rate implies that 308,426 individuals within Los Angeles County were in need of mental health services in 2003.

Unserved

During FY 2002-2003,196,220 individuals received at least one service contact with the Department of Mental Health. Our stakeholders, therefore, calculated that 112,207 individuals who were in need of mental health services were unserved.

Graph 1: Los Angeles County Department of Mental Health Service Need Estimates for FY 02-03



Penetration Rates

	County Poverty Population (200% and below)		County Population		Penetration Rate of DMH Clients (served FY 02-03 excluding other and unknown ethnicities) into County Poverty Population 200% and below	
	Number	%	Number	%	Number	Rate
Total	3,516,838	100.00%	9,972,202	100.00%	145,711	4.14%
African American	447,482	12.72%	966,835	9.69%	44,803	10.01%
Asian Pacific Islander	401,518	11.42%	1,329,210	13.33%	7,183	1.79%
Latino	2,052,916	58.37%	4,609,970	46.23%	52,438	2.55%
Native American	13,321	0.38%	30,720	0.31%	830	6.23%
White	601,601	17.11%	3,035,467	30.44%	40,457	6.72%

A simple application of the overall prevalence rates of SED/SMI for all age groups living in poverty—8.77%—would imply that within the poverty population, DMH would serve each ethnic subgroup at a rate of 8.77%.

Using this over-simplified approach, data from the table above suggest that the African American subgroup is overrepresented in DMH service population (10.01%) while all other groups are under-represented. The Asian Pacific Islander subgroup is the most severely underrepresented at a rate of 1.79%. Note, of course, that numbers served do

not necessarily mean that that those receiving services are receiving the services they need, or services that will help them progress toward recovery and wellness.

Due to the limitations in available data, we relied upon the estimated prevalence rate of 8.77% developed by the California Department of Mental Health. We hope to develop more nuanced analyses in the future, including assessments of actual usage by ethnicity, by age group, and by service area.

2) Using the format provided in Chart A, indicate the estimated total number of persons needing MHSA mental health services who are already receiving services, including those currently fully served and those underserved/ inappropriately served, by age group, race ethnicity, and gender. Also provide the total county and poverty population by age group and race ethnicity.

In Chart A, we have substituted the phrase “adequately served” for “fully served.” We define adequately served as individuals who have received one thousand dollars or more of services during the fiscal year excluding inpatient, jail and other institutional services. Underserved and inappropriately served population, therefore, include individuals who have received less than one thousand dollars in services.

Chart A: Service Utilization by Race/Ethnicity

Children & Youth	Adequately Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	19,631	11,519	6,207	3,775	41,132	100.00%	678,182	100.00%	2,485,090	100.00%
African American	3,342	2,134	1,068	1,013	7,557	18.37%	87,211	12.86%	244,771	9.85%
Asian Pacific Islander	513	318	164	111	1,106	2.69%	42,433	6.26%	241,408	9.71%
Latino	11,613	7,198	4,125	2,711	25,647	62.34%	488,220	71.98%	1,503,218	60.48%
Native American	111	59	24	14	208	0.51%	3,118	0.46%	6,112	0.25%
White	3,048	1,787	789	411	6,035	14.67%	44,142	6.51%	474,648	19.10%
Other	1,513	1,124	736	444	3,817	9.28%				

Transition Age Youth	Adequately Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	9,312	7,174	5,800	4,625	26,911	100.00%	612,288	100.00%	1,466,904	100.00%
African American	2,388	1,846	1,441	1,148	6,823	25.36%	84,501	13.80%	118,178	8.06%
Asian Pacific Islander	417	321	198	156	1,091	4.05%	71,278	11.64%	162,345	11.46%
Latino	3,568	3,743	2,124	1,694	11,131	37.61%	388,828	61.68%	783,887	54.41%
Native American	52	41	18	24	141	0.54%	1,782	0.28%	4,245	0.21%
White	1,815	1,476	1,115	803	5,431	21.18%	78,883	13.15%	137,157	11.01%
Other	872	745	874	817	3,212	12.21%				

Adult	Adequately Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	19,556	24,824	15,779	18,125	78,284	100.00%	1,735,831	100.00%	4,582,527	100.00%
African American	4,118	6,131	4,181	5,381	21,221	27.11 %	214,718	11.37 %	413,816	8.58%
Asian Pacific Islander	1,577	2,102	558	641	4,771	6.10 %	211,015	11.88 %	673,267	14.67 %
Latino	4,123	6,113	3,161	4,141	17,464	24.15 %	1015,711	57.94 %	1173,668	43.87 %
Native American	113	167	84	107	501	0.64 %	2484	0.43 %	15,481	0.34 %
White	8,411	8,116	4,138	5,151	25,101	32.17 %	211,011	17.27 %	1413,585	33.31%
Other	1113	2071	1117	1011	7,221	9.23 %				

Older adult	Adequately Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
Total	1,649	3,364	1,792	3,122	9,927	100.00%	490,537	100.00%	1,437,681	100.00%
African American	211	572	191	603	1,827	18.41 %	74,191	15.11 %	144,178	10.03%
Asian Pacific Islander	118	304	101	174	846	8.52 %	78,887	16.07 %	210,119	14.62 %
Latino	180	736	387	871	2,184	21.72 %	193,850	39.43 %	330,877	23.00 %
Native American	5	11	4	11	31	0.33 %	876	0.18 %	4,862	0.34 %
White	687	1,361	881	1,806	4,827	38.56 %	172,715	36.23 %	746,575	52.14%
Other	147	381	215	373	1,021	10.48 %				

3) Provide a narrative discussion of the ethnic disparities in the fully served, underserved and inappropriately served populations in your county by age group as identified in Chart A. Include any available information about their age and situational characteristics as well as race ethnicity, gender, primary language, sexual orientation, and special needs.

Based on the summary data in the table below, there are no substantial ethnic disparities between the adequately served and the inappropriately served and underserved populations across ethnic populations. That is, all ethnic groups for which we have data show similar percentages of adequately served and inappropriately or under served. Such a statement is not intended to mask or ignore the significant disparities in access to services documented in prior and future sections. It is only intended to reflect the limited reality captured in the table below: namely, that when comparing the percentages of adequately served and inappropriately or underserved within a given ethnic group, the percentages are comparable between ethnic groups.

	Adequately Served		Inappropriately/ Under Served		
	#	%	#	%	Total
Total	97,029	62%	59,225	38%	156,254
African American	24,710	60%	16,431	40%	41,141
Asian Pacific Islander	5,745	73%	2,088	27%	7,833
Latino	32,132	64%	17,929	36%	50,061
Native American	567	65%	310	35%	877
White	24,957	62%	15,605	38%	40,562
Other	8,919	57%	6,862	43%	15,781

The limitations of existing data sources do not permit an adequate analysis of ethnic disparities among fully served, underserved and inappropriately served populations especially among local service areas. General observations and extensive information collected by Stakeholder groups during the assessment phase of our planning effort, however, suggest that significant disparities currently exist among ethnic populations in access, delivery, and impact of mental health services.

The Stakeholders have identified ethnic parity as a high priority. They have chosen the allocations for Full Service Partnerships as the first set of investments for which they will set targets by ethnicity, by age group, by service area. Moreover, the aggressive outreach and engagement efforts to be funded with one-time funding in year 1, and sustained with on-going funding in years 2 and 3, will help us continue to develop our understanding of the specific needs of underserved ethnic and cultural communities as we apply the lessons of our first years of MHSA investments to the system's overall budget.

4) Identify objectives related to the need for, and the provision of, culturally and linguistically competent services based on the population assessment, the county's threshold languages and the disparities or discrepancies in access and service delivery that will be addressed in this Plan.

Significant disparities in access to services exist among multiple ethnic and cultural communities in Los Angeles County. For example, Hispanic and Asian and Pacific Islander communities are significantly under-represented within the mental health system, as are many other communities that are not currently reflected by the existing data sources. Specifically, census and other data reports show members of the Armenian, Russian, and Persian communities as *White* but community members from these ethnic groups have made clear to the Stakeholders that their language needs and cultural sensibilities justify them as a category distinct from White. Delegates from the African American community have also presented data to help illustrate ways in which members from their communities are often inappropriately served.

Our intention is to use MHSA investments to help us learn how to more effectively and efficiently create the broad range of supports that individuals need to accelerate their recovery and progress toward wellness across multiple ethnic and cultural communities. Specifically, we are committed to using MHSA funds to learn how to set and meet targets for different populations so that we can pursue a more ambitious agenda of addressing disparities in access to services in coming years.

We have begun to act on this commitment in the following ways. We first identified several criteria to help us set preliminary targets for Full Service Partnerships to different ethnic groups by age and by service area (see discussions below). These criteria included: poverty by age by ethnicity by service area (see tables above); numbers of uninsured by age by ethnicity by service area; and numbers of households where English is not the primary language by age by ethnicity by service area.

We quickly discovered that reliable data by age by ethnicity by service area only exists for the poverty criterion; the other two criteria can only be analyzed Countywide or by service area, but not by age by ethnicity by service area.

The delegates decided to start with the poverty data and calculate countywide slots by ethnicity. We will then analyze the demographic data for the various focal populations by service area and begin to develop coherent designs for Full Service Partnerships that will stay within the recommended allocations. We will then monitor these targets on a quarterly basis, reporting back to the delegates our progress and identifying where we may need to strengthen our outreach and engagement efforts. Additionally, we will create specialized slots for dispersed ethnic and special populations —e.g., American Indians—to ensure that we are creating services for those populations and learning how to improve the larger service system's efforts on their behalf.

One last calculation that we have done relative to the allocation of Full Service Partnerships is to set targets for the uninsured in Los Angeles County. We have set ambitious targets for reaching the uninsured in each age group in order to insure that these funds provide support and hope for the most vulnerable citizens with mental health needs in our community.

PART II, SECTION III: Identifying Initial Populations for Full Service Partnerships

1) From your analysis of community issues and mental heath needs in the community, identify which initial populations will be fully served in the first three years. Please describe each population in terms of age and the situational characteristics described above (e.g., youth in the juvenile justice system, transition-age youth exiting foster care, homeless adults, older adults at risk of institutionalization, etc.). If all age groups are not included in the Full Service Partnerships during the three-year plan period, please provide an explanation specifying why this was not feasible and describe the county's plan to address those age groups in the subsequent plans.

Given the large numbers of people who are unserved in Los Angeles County, it is not possible for us to fully serve any population through the CSS Plan. A more accurate description of the impact of these funds in Los Angeles County is this: for individual members of the focal populations we have chosen, and in some cases their families, we will be able to fully serve their needs through the CSS Plan.

CHILDREN 0-15

In the August 1, 2005 guidelines, the State Department of Mental Health recommended several groups of children as candidates for target populations. These groups included children and youth between the ages of 0 and 18, [1] or Special Education students through the end of the school year in which they turn 22 and their families, who have serious emotional disorders, and who are not currently being served. This population generally consists of:

- Youth and their families who are uninsured, under-insured and/or youth who are not eligible for Medi-Cal because they are detained in the juvenile justice system;
- Homeless youth, youth in foster care placed out-of-county and youth with multiple (more than two) foster care placements; and
- Children and youth who are so underserved that they are at risk of homelessness or out-of-home placement. (Mental Health Services Act Community Services and Supports: Three Year Program and Expenditure Plan Requirements, August 1, 2005, p. 21. From this point forward, this document will be referred to as the State CSS Guidelines.)

[1] The first draft of the CSS guidelines issued by the State set the age range for children at 0-15. In subsequent versions of the guidelines, including the final guidelines, the State established the age range for children at 0-18, creating an overlap with Transition Age Youth. We have opted to keep the age range for children at 0-15, and to create ad hoc structures for the Children and Transition Age Youth workgroups to work together when they are addressing issues that cross between the two populations.

Stakeholder delegates embraced the State's recommended focal populations, though many of the sub-groups specified by the State for children actually fall within the focal populations identified by the Transition Age Youth (TAY) workgroup (see the TAY discussion in the next section). The delegates further defined the recommended focal populations as follows.

The focal populations would include children (ages 0 to 15) with severe emotional disorders (SED) and their families, with a priority placed on individuals with co-occurring disorders, recent hospitalizations, psychotic disorders, or showing symptoms of trauma experiences. In particular, we will focus on:

- Pre-natal to 5 year olds who are at high risk of being expelled from pre-school, involved with or at high risk of being detained by the Department of Children and Family Services (DCFS); or children of parents or caregivers who have SED or severe and persistent mental illness, or have a co-occurring substance abuse disorder;

- Children who have been removed from their homes or who are at high risk of being removed from their home by DCFS, and who are in transition to less restrictive placements;

- Children who are experiencing the following at school:
  - Expulsion or suspension, or high risk of either;
  - Violent behaviors;
  - Drug possession or use;
  - Suicidal and/or homicidal ideation; and/or
  - Truancy; and

- Youth involved with the Probation Department who are being treated with psychotropic medications and who are transitioning back into less structured home and community settings.

TRANSITION AGE YOUTH 16-25

On August 1, 2005, State Department of Mental Health guidelines recommended several groups of Transition Age Youth as candidates for target populations. These groups included transition age youth between the ages of 16 and 25, who are currently unserved or underserved who have serious emotional disorders and who are:

- Homeless or at imminent risk of being homeless;
- Youth who are aging out of the child and youth mental health, child welfare and/or juvenile justice systems;
- Youth involved in the criminal justice system or at risk of involuntary hospitalization or institutionalization; and
- Transition age youth who have experienced a first episode of major mental illness. (State CSS Guidelines, p. 21)

The delegates embraced the State's recommended focal populations, and further refined them. The delegates intend to make a long-term commitment to all transition age youths between the ages of 16 and 25: (1) who have severe emotional disturbances (SED) or Severe Mental Illnesses (SMI) that result in significant functional impairment, or (2) who demonstrate significant social, emotional, educational and/or occupational impairments that could meet the criteria for an SED and/or SMI diagnosis, and (3) who have dual diagnoses or co-occurring disorders, including substance abuse disorders and others.

During the first three years of the CSS Plan, however, we will focus on those youths who are unserved, underserved or inappropriately served, including those who are homeless, or at risk of homelessness, and/or youth aging out of the children's mental health, child welfare, and juvenile justice systems.

In particular, we will give priority to youths who:

- Have been in or are leaving long term institutional settings—e.g., level 14 group homes—including those youths who, though diagnostically qualified for level 14 group homes, were living in other settings;

- Have been in hospitals, Institutes for Mental Disease (IMDs), Community Treatment Facilities, jails, and/or probation camps; and

- Have experienced their first psychotic break.

ADULTS 26-59

The State Department of Mental Health August 1, 2005 guidelines recommended several groups of adults with serious mental illness as potential focal populations, including adults with a co-occurring substance abuse disorder and/or health condition who are either not currently served and meet one or more of the following criteria:

- Homeless;
- At risk of homelessness, such as youth aging out of foster care or persons coming out of jail;
- Involved in the criminal justice system including adults with child protection issues; or
- Frequent users of hospital and emergency room services;

Or who are so underserved that they are at risk of:

- Homelessness, such as persons living in institutions or nursing homes;
- Criminal justice involvement;
- Institutionalization; or
- Transition age older adults (often between the ages of 55 and 59) who are aging out of the adult mental health system and at risk of any of the above conditions or situational characteristics. (State CSS Guidelines, p. 21)

The delegates embraced the State's recommended focal populations, and further refined them. We will focus our initial CSS Full Service Partnerships for adults with serious mental illness, including people who have co-occurring disorders and/or have suffered severe trauma, who are so unserved or underserved as to be:

- Homeless;
- In jail;
- Frequent users of hospitals or emergency rooms;
- In other institutional settings, including State Hospitals, IMDs, Urgent Care Centers, various residential treatment and other facilities; or
- With family members or in other settings and, because of their mental illness, are at imminent risk of homelessness, jail, and/or institutionalization.

OLDER ADULTS 60+

The August 1, 2005 guidelines issued by the State Department of Mental Health recommended several groups of Older Adults 60 and older as candidates for target populations. These groups include older adults 60 years and older with serious mental illness, including older adults with co-occurring substance abuse disorders and/or other health conditions, who are not currently being served and:

- Have a reduction in personal or community functioning;
- Are homeless; and/or
- At risk of homelessness, institutionalization, nursing home care, hospitalization and emergency room services; or
- Are so underserved that they are at risk of any of the above.

Transition age older adults may be included under the older adult population when appropriate. (State CSS Guidelines, pp. 21-22)

The delegates embraced the State's recommended focal populations, and further refined them. We will focus our initial CSS Full Service Partnerships for older adults on individuals who are 60 years and older with serious mental illness, including older adults who are:

- With co-occurring disorders, including substance abuse disorders, developmental disorders, medical disorders and cognitive disorders with a primary diagnosis of mental illness;
- At imminent risk for placement in Skilled Nursing Facility (SNF) or released from SNF, possibly conserved;
- Adult Protective Service-referred clients with a history of self-neglect or abuse and who are typically isolated;
- At high risk of going to jail or released from jails;
- Intensive service recipients (clients with 6 or more hospitalizations in the past 12 months);

- Currently in the system and are aging up in the system, e.g., consumers who have suffered from severe mental disorders in earlier years who are now becoming senior citizens, perhaps currently in adult "ACT-like programs;" and
- At high risk for suicide.

2) Please describe what factors were considered or criteria established that led to the selection of the initial populations for the first three years. (Distinguish between criteria used for each age group if applicable.)

In selecting these priority populations, workgroups focused on a number of strategic and heart-felt considerations, including:

- The CSS Guidelines' focus on adults and older adults with the most severe and persistent mental illness, and children and youths who are struggling with the most severe emotional disturbances;
- Opportunities to use the MHSA funds to help leverage change that goes well beyond the immediate impact of the new dollars;
- The relative flexibility of the MHSA funds compared to other resources available for mental health services and thus the opportunity to use MHSA funds to address some of the community's most intractable issues and most vulnerable populations;
- The desire to create early successes to build momentum for larger-scale change; and
- The desire to finally address—in concrete ways—issues of disparities in access to services and disparities in outcomes.

3) Please discuss how your selections of initial populations in each age group will reduce specific ethnic disparities in your county.

Conservative estimates (see analysis above) calculate the unmet need in Los Angeles County at over 112,000 people; when fully staffed and operational, the Full Service Partnerships will support 4,333 people and their families. The relative impact that these initial Full Service Partnerships will have, therefore, is small. Our intention, however, is to use these investments to help us learn how to more effectively and efficiently create the broad range of supports that individuals need to accelerate their recovery. Moreover, we are committed to using these new funds to learn how to set and meet targets for different populations so that we can pursue a more ambitious agenda of addressing disparities in access to services in coming years.

We have begun to act on this commitment in the following ways. We first identified several criteria to help us set preliminary targets for Full Service Partnerships to different ethnic groups by age and by service area. These criteria included: poverty by age by ethnicity by service area (see tables above); numbers of uninsured by age by ethnicity by service area; and numbers of households where English is not the primary language by age by ethnicity by service area.

We quickly discovered that reliable data by age by ethnicity by service area only exists for the poverty criterion; the other two criteria can only be analyzed Countywide or by service area, but not by age by ethnicity by service area.

The delegates decided to start with the poverty data and calculate countywide slots by ethnicity. We will then analyze the demographic data for the various focal populations by service area and begin to develop coherent designs for Full Service Partnerships that will stay within the recommended allocations. We will then monitor these targets on a quarterly basis, reporting back to the delegates our progress and identifying where we may need to strengthen our outreach and engagement efforts. Additionally, we will create specialized slots for dispersed ethnic and special populations —e.g., American Indians—to ensure that we are creating services for those populations and learning how to improve the larger service system's efforts on their behalf.

One last calculation that we have done relative to the allocation of Full Service Partnerships is to set targets for the uninsured in Los Angeles County. We have set ambitious targets for reaching the uninsured in each age group in order to insure that these funds provide support and hope for the most vulnerable citizens with mental health needs in our community.

PART II, SECTION IV: Identifying Program Strategies

1) If your county has selected one or more strategies to implement with MHSA funds that are not listed in this section, please describe those strategies in detail in <u>each</u> applicable program work plan including how they are transformational and how they will promote wellness/recovery/resiliency and are consistent with the intent and purpose of the MHSA. No separate response is necessary in this section.

All strategies chosen by Los Angeles County are listed in this section.

PART II, SECTION V: Assessing Capacity

1) Provide an analysis of the organization and service provider strengths and limitations in terms of capacity to meet the needs of the racially and ethnically diverse populations in the county. This analysis must address the bilingual staff proficiency for threshold languages.

2) Compare and include an assessment of the percentages of culturally, ethnically, and linguistically diverse direct service providers as compared to the same characteristics of the total population who may need services in the county and the total population currently served in the county.

For the purpose of answering these two questions, we are relying on data collected in FY 2002-2003 describing the staff of the Los Angeles Department of Mental Health and the organizations that provide services under contract with the Department. The data has several limitations including: timeliness; gaps in reporting by some contracting agencies; lack of data by sub-populations, particularly within the Asian and Pacific Islander community, and others.

In particular, we mostly have data related to the languages identified by Los Angeles County as threshold languages: Armenian, Cambodian, Cantonese, English, Farsi, Korean, Tagalog, Mandarin, Russian, Spanish, and Vietnamese. Many more languages are spoken in Los Angeles County. The data, therefore, that we have may systematically understate many of the needs for underserved communities. Still, we are using the existing data to begin documenting what is an obvious and ever increasing need in Los Angeles County for language proficient and culturally sensitive and aware staff and services.

General Analysis

Table 1 reflects the overall ethnic composition of the Department's workforce.

Table 1

2003 Countywide Workforce Assessment by Function and Ethnicity

	Administrative		Direct Services		Support		Grand Total	
ETHNICITY	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
African American	252	20.59%	1524	16.55%	991	27.05%	2767	19.63%
American Native	3	0.25%	51	0.55%	19	0.52%	73	0.52%
Asian Pacific Islander	177	14.46%	1045	11.35%	420	11.46%	1642	11.65%
Hispanic	255	20.83%	1536	16.68%	955	26.06%	2746	19.48%
Other		0.00%	2	0.02%	1	0.03%	3	0.02%
Unknown/Not Reported	70	5.72%	581	6.31%	224	6.11%	875	6.21%
White	467	38.15%	4469	48.53%	1054	28.77%	5990	42.49%
Grand Total	**1224**		**9208**		**3664**		**14096**	

Source: LAC-DMH Planning Files, July 2002 – June 2003; LAC-DMH Planning Files, July 1997 – June 1998

The percentage of Caucasian staff decreased from 48.3% in 1998 to 42.5% in 2003. The percentage of African American staff nearly doubled from 10.7% to 19.6% over the same time period. The percentage of Asian Pacific Islanders staff increased from 8.3% to 11.7%. While the percentage of Hispanic staff associated with the provision of

direct/clinical services increased from 15.4% to 16.7%, the overall percentage of the Hispanic staff decreased from 25.8% to 19.5%.

Table 2 compares the ethnic and cultural composition of the County's total population to the ethnic and cultural composition of the Department's workforce.

Table 2

2003 Countywide Comparison - Total Population and the Workforce by Ethnicity

ETHNICITY	Population	Percent	Staff	Percent	% of gap b/w staff & pop
African American	901,472	9.5%	2767	19.63%	+10.13%
American Native	25,609	0.3%	73	0.52%	+0.22%
Asian Pacific Islander	1,147,834	12%	1642	11.65%	-0.35%
Hispanic	4,242,213	44.6%	2746	19.48%	-25.12%
Other	19,935	0.2%	3	0.02%	-0.18%
White	2,959,614	31.1%	5990	42.49%	+11.39%
2 or more races Unknown/Not Reported	222,661	2.3%	875	6.21%	+3.91%
Grand Total	**9,519,338**	**100.00%**	**14096**	**100.00%**	

Source: LAC-DMH Planning Files, July 2002 – June 2003 and Demographic estimates for July 2003 prepared on 4/2003 for County of Los Angeles, CAO

Table 2 reveals an over-representation of White/Caucasian and African-American staff members compared to the overall population, and a substantial need for more Hispanic staff. We are not currently able to provide more specific analyses of sub-populations, particularly within the Asian and Pacific Islander population due to limitations in existing data sources. More detailed analyses in subsequent years will help us assess our recruiting needs for establishing adequate ethnic representation among our staff members.

Table 3 compares the ethnic and cultural composition of the County's total population to the ethnic and cultural composition of the Department's direct services workforce.

Table 3

2003 Countywide Comparison - Total Population and Direct Services Staff by Ethnicity

ETHNICITY	Population	Percent	Staff	Percent	% of gap b/w staff & pop
African American	901,472	9.5%	1524	16.55%	+7.05%
American Native	25,609	0.3%	51	0.55%	+0.25%
Asian Pacific Islander	1,147,834	12%	1045	11.35%	-0.65%
Hispanic	4,242,213	44.6%	1536	16.68%	-27.92%
Other	19,935	0.2%	2	0.02%	-0.18%
White	2,959,614	31.1%	4469	48.53%	+17.43%
2 or more races Unknown/Not Reported	222,661	2.3%	581	6.31%	+4.01%
Grand Total	**9,519,338**	**100.00%**	**9208**	**100.00%**	

Source: LAC-DMH Planning Files, July 2002 – June 2003 and Demographic estimates for July 2003 prepared in 4/2003 for County of Los Angeles, CAO

Table 3 reveals a similar pattern as in Table 2: an over-representation of White/Caucasian and African-American direct services staff compared to the overall population, and a substantial need for more Hispanic staff. Again, we are not able, at the present time, to provide more specific analyses of sub-populations, particularly within the Asian and Pacific Islander population. More detailed analyses in subsequent years will help us determine where we may need to recruit staff for more appropriate ethnic representation among sub-populations.

Table 4 compares threshold languages spoken within the overall County population and those spoken within the Department's total workforce.

Table 4

2003 Countywide Comparison - Total Population and the Workforce Threshold Language

LANGUAGE	Population	Percent	Staff	Percent	% of gap b/w staff & pop
Armenian	138,015	1.6%	73	0.52%	-1.08%
Cambodian	29,117	0.3%	41	0.29%	-0.01%
Cantonese/Mandarin/Other	287,724	3.3%	103	0.73%	-2.57
English	4,032,614	45.9%	9,186	65.17%	+19.27%
Farsi	68,192	0.8%	4	0.03%	-0.77%
Korean	165,158	1.9%	156	1.11%	-0.79%
Other/Unknown	1,442.604	15%	901	6.39%	-8.61%
Russian	44,048	0.5%	89	0.63%	+0.13%
Spanish	3,330,935	37.9%	2,988	21.20%	-16.7%
Tagalog	195,671	2.2%	279	1.98%	-0.22%
Vietnamese	71,664	0.8%	118	0.84%	+0.04%
Grand Total	**9,805,742***	**110.2%***	**14,096**	**100.00%**	

Source: LAC-DMH Planning Files, July 2002 – June 2003 and Census 2000, SF3, Table PCT 10.
** Note: Individuals in the general population are counted in each language reported spoken. Since one person can speak more than one language, numbers will be higher and the percentage of the overall population will be greater than 100%.*

This table reflects an overall need for bilingual staff in many threshold languages, particularly Spanish, Cantonese/Mandarin/Other, Armenian, Farsi, and Korean. The large numbers of people who are reflected as Other/Unknown (15%) pose a different challenge for the Department. We need to develop more sophisticated technologies to assess the language needs of this large segment of the County's population.

Table 5 compares threshold languages spoken within the overall County population and those spoken within the Department's direct services workforce.

Table 5

2003 Countywide Comparison - Total Population and Direct Services Staff by Threshold Language

LANGUAGE	Population	Percent	Staff	Percent	% of gap b/w staff & pop
Armenian	138,015	1.6%	42	0.46%	-1.14%
Cambodian	29,117	0.3%	33	0.36%	+0.06%
Cantonese/Mandarin/Other Chinese	287,724	3.3%	69	0.75%	-2.55%
English	4,032,614	45.9%	6,147	66.76%	+20.86%
Farsi	68,192	0.8%	4	0.04%	-0.76%
Korean	165,158	1.9%	128	1.39%	-0.51%
Other/Unknown	1,442.604	15%	629	6.83%	-8.17%
Russian	44,048	0.5%	67	0.73%	+0.23%
Spanish	3,330,935	37.9%	1,815	19.71%	-18.19%
Tagalog	195,671	2.2%	110	1.19%	-1.01%
Vietnamese	71,664	0.8%	73	0.79%	-0.01%
Grand Total	**9,805.742***	***110.2%**	**9,208**	**100.00%**	

*Individuals are counted in each language reportedly spoken
Source: LAC-DMH Planning Files, July 2002 – June 2003 and Census 2000, SF3, Table PCT 10

This table reflects an overall need for bilingual direct service staff fluent in many threshold languages, particularly Spanish, Cantonese/Mandarin/Other Chinese, Armenian, Farsi, and Tagalog. Again, the large numbers of people who are reflected as Other/Unknown (15%) pose a different challenge for the Department. We need to develop more sophisticated technologies to assess the language needs of this large segment of the County's population.

Some limitations of this data and general analysis are worth noting as cautions for stakeholders and others as we move to develop strategies for addressing the clear need for more culturally diverse and competent staff.

For example, using general ratios of providers to population could suggest that all ethnic communities and all geographic communities have equal need for and equal access to mental health services, though of course experience tells us that needs and access can vary dramatically between and within ethnic and geographic communities. Multiple issues affect real-world access to mental health services, including cultural attitudes toward mental health issues, socio-economic status, fear of reprisals for accessing services, and many other factors.

Moreover, that a staff member speaks a particular language does not by itself assure that that staff member in fact provides services in that language. Ratios of staff to population may therefore overstate the availability of language appropriate services.

A further nuance of this data is that we have used household language as the basis for comparison of the provider to population ratio. One possible shortcoming of this data is that many households, though using a language other than English at home, are bicultural, and some or all members of these households could be proficient in English. Generally, the more recent a family has immigrated to this country, the less likely that family is to be bicultural.

As noted in the introduction of this section, Table 5 and most of the tables in this section only reflect data related to the threshold languages. We know there are many smaller, underserved communities that have equally critical language needs in accessing mental health services. One small illustration: there is no Hmong-speaking provider for the Hmong community in Los Angeles. According to Census 2000, there are 3,569 Laotians in Los Angeles County; 2,764 (77.4%) are foreign-born. Of those Laotians who are 5 years old and over, more than half (2,003 or 52.7%) speak English less than very well. Yet there are only 3 bilingual Laotian staff (2 direct service providers and 1 support services staff) for this entire community. This is a typical challenge that repeats itself for multiple smaller ethnic communities across the County.

We share these reflections as caution about how much more work there is to be done for us to have a comprehensive analysis of the language and cultural competence needs for the County's workforce.

Table 6 compares the ratio of Mental Health Providers to the general population in California to the ratio of Mental Health Providers to the general population in Los Angeles County. The ratio is higher for the County than it is for the State.

Table 6

Statewide Comparison

STATE OF CALIFORNIA

Total General Population	Licensed MH Providers
33,871,648	**62,723**
State Ratio to General Population	
1:540	

LOS ANGELES COUNTY

Total General Population	Licensed MH Providers
9,519,338	**14,917**
County Ratio to General Population	
1:638	

Sources: The Mental Health Workforce: Who's Meeting California's Needs – Tina McRee et.al. (2003); Census Bureau 2000

Strengths of the current system

1. The demographic composition of the Los Angeles County Department of Mental Health and its contract providers as presented in tables 1, 2, 3, 4, and 5 reflects a growing ethnic, cultural, and language diversity within the County's workforce. The percentage of the Caucasian staff decreased from 48.3% in 1998 to 42.5% in 2003. The percentage of the African American staff almost doubled from 10.7% to 19.6%, and the percentage of the Asian Pacific Islanders staff increased from 8.3% to 11.7% during the same period.

2. Among all staff members, 35% speak at least one language in addition to English. Additionally, about 30% speak two or more languages other than English. The total bi-lingual capability of all staff includes 36 other than English. We do not have data yet on those staff who are fluent in American Sign Language.

3. During the past five years, DMH and its contract providers have been successful in increasing both the ethnic diversity and the language capability of the workforce delivering direct services. Countywide, more than 20 different ethnicities are represented in the direct service provider staff, including: African Americans 16.6%; Asian Pacific Islanders 11.4%; Caucasians 48.5%; Hispanics 16.7%; and American Natives 0.6%.

4. 27.3% of the organization's direct service providers speak one or more threshold languages other than English, not including American Sign Language; 33.7% speak one of 34 languages other than English, not including American Sign Language, an increase from 20 languages spoken in 1998.

Limitations and challenges of the current system

Countywide, the system's ethnic diversity and language abilities are improving, yet substantial challenges clearly remain.

4. Compared to the County's overall population, Caucasian and African American staff members are over-represented. Hispanic staff members are substantially underrepresented, as are Asian and Pacific Islander staff members. Beyond the data reflected in tables 1-5 above, Table 7 reflects this disparity in a different way, comparing staff to population ratios by ethnicity.

Table - 7

Ethnicity	County Population 2000 Census		Direct Service Staff (DSS)		Ratio DSS to Gen. Pop.
	#	%	#	%	
African American	901,472	9.5	1,524	16.55%	1:592
American Indian	25,609	0.3	51	0.55%	1:502
Asian Pacific	1,147,834	12.1	1,045	11.35%	1:1098
Hispanic	4,242,213	44.6	1,536	16.68%	1:2762
White	2,959,614	31.1	4,469	48.53%	1:662
Other/Unknown	242,596	0.3	583	6.33%	1:416
TOTAL	**9,519,338**	**100**	**9,208**	**100**	**1:672**

Sources: The Mental Health Workforce: Who's Meeting California's Needs – Tina McRee et.al. (2003) Census Bureau 2000 DMH Cultural Competency Plan (2004)

While ratios for all populations are extremely high, ratios for Hispanic and Asian Pacific Islanders staff are substantially higher still.

5. Another dimension of the challenges facing the Los Angeles County system is captured in Table 8, comparing the ratios of different licensed professions for the State's and County's general populations.

Table - 8

	Total Population	Licensed Providers	Ratio	LCSW	Ratio	MFT	Ratio
LA	**9,519,338**	14,917	1:638	3,624	1:2629	6,050	1:1573
CA	**33,871,648**	62,723	1:540	13,717	1:2469	23,259	1:1456

	Psychologists	Ratio	LPT	Ratio	RNMH	Ratio	Psychiatrist	Ratio
LA	3,229	1:2948	1,119	1:8507	116	1:82063	779	1:1220
CA	11,279	1:3003	9,179	1:3690	419	1:80839	4,870	1:6955

Sources: The Mental Health Workforce: Who's Meeting California's Needs – Tina McRee et.al. (2003) Census Bureau 2000 DMH Cultural Competency Plan (2004)

In all professional disciplines except for psychology and psychiatry, Los Angeles County lags behind the state ratio of clinician to general population, suggesting a prominent need for licensed clinical social workers, marriage and family therapists, licensed psychiatric technicians, and mental health registered nurses. Such reflections, of course, are only a crude beginning to what ultimately must be a much more sophisticated analysis. For example, that we have more psychologists and psychiatrists than the State average does not reveal very much about need, particularly for such professionals who are fluent in languages other than English and who provide services to communities who speak those languages.

6. Table 5 above documents the need for hiring and retaining bilingual direct service staff, particularly staff members who speak Spanish, Armenian, Farsi, Korean, Tagalog, Cantonese, Mandarin, and other Chinese languages.

7. Table 5 also documents the system's current data limitations. Being unable to document the primary language of 15% of the County's population creates a significant barrier to the Department's ability for developing effective staff recruitment goals.

In addition to the organizational and service provider challenges identified above, there are several Statewide and local trends that further impact the system's capacity to meet the needs of racially, ethnically, and linguistically diverse populations in the Los Angeles County.

1. The California Mental Health Planning Council has identified many challenges facing ethnic minorities seeking to obtain appropriate credentials to work in the mental health field. Personal challenges include the lack of self-confidence, cultural barriers, and tuition/financial barriers among others. Academic challenges include the length of time and the funds needed to complete the program, negative experiences with college recruiters, lack of knowledge about the program's requirements, and curriculum that may be or may appear to be culturally insensitive. Larger cultural challenges may include the stigma of mental illness, school expectations, distrust of higher education, gender discrimination (woman should not attain a higher degree), and others.

2. The diversity of the Los Angeles County population creates a strong competition for bilingual and bicultural professionals in general and mental health practitioners in particular, often making it difficult to hire new staff at prevailing wage rates within the Department and within contract providers.

3. Los Angeles County has identified 12 threshold languages, but non-threshold language needs have been increasing as more monolingual groups have been immigrating to Los Angeles County, including large groups of refugees from Arabic-speaking countries, Bosnia, Kosovo, Ethiopia, Somalia, Senegal, and many others.

4. The most current data reflecting individuals who have completed high school in California show that only 52.4% of Hispanic students and 56.8% of Black/non-Hispanic students graduate, creating much smaller pools of students who could be eligible to pursue higher education or professional degrees, including degrees for work in the mental health profession.

3) Provide an analysis and include a discussion of the possible barriers your system will encounter in implementing the programs for which funding is requested in this Plan and how you will address and overcome these barriers and challenges. Challenges may include such things as difficulty in hiring staff due to

human resource shortages, lack of ethnically diverse staff, lack of staff in rural areas and/or on Native American reservations and rancherias, difficulties in hiring clients and family members, need for training of staff in recovery/wellness/ resilience and cultural competency principles and approaches, need to increase collaborative efforts with other agencies and organizations, etc.

1. The challenges highlighted in the responses to the first 2 questions of this section—shortages of Hispanic, API, and other ethnic staff, and shortages of staff fluent in multiple threshold and other non-English languages—represent substantial barriers faced by Los Angeles County as we move to implement our CSS Plan. We have devoted substantial resources within our projected one-time funds to accelerate the identification and training of bi-lingual staff, and to facilitate students and other community members becoming licensed clinical social workers, marriage and family therapists, licensed psychiatric technicians, and other community based mental health workers.

2. County regulations governing the hiring of staff and entering into of contracts with County providers may present substantial barriers to our timely implementation of the CSS Plan. We have created an ad hoc task force including senior Department officials and representatives from the CAO, County Counsel's office, County HR, and other relevant departments to anticipate and develop appropriate responses to these potential challenges.

3. Ensuring that staff at all levels of the service delivery system are grounded in and committed to the fundamental principles of recovery is an on-going challenge within the system. We will devote substantial one-time funds to providing training in recovery and wellness to staff throughout Los Angeles County.

4. Ensuring that staff at all levels of the service delivery system are grounded in and committed to the fundamental principles of cultural awareness and competency is also an on-going challenges. We will devote substantial one-time funds to providing training in principles and practices of cultural competency to staff throughout Los Angeles County.

5. One of the substantial barriers to housing projects that support people with mental health needs is opposition from local communities where the projects will be sited. We will use some of our one-time funds to develop a strategic plan for systematically responding to and overcoming the "Not in My Backyard (NIMBY)" phenomenon.

6. Creating trusting relationships with people within some of the focal populations for our Full Service Partnerships—e.g., transition age youth, people with severe and persistent mental illnesses who are at home and not within any current system—will pose a substantial challenge in the early months of our Full Service Partnership work. All of the Full Service Partnership investments presume that substantial dollars will be invested early on to outreach and engagement. We have also devoted substantial one-time dollars to outreach and engagement efforts.

7. Designing and implementing an effective information and technology system that will allow us to effectively track outcomes and other critical performance measures will present another substantial challenge to implementing the CSS Plan. The Department has devoted substantial financial and staff resources to addressing this issue over the past year and a half. More effort and resources are still required.

8. Transportation to needed services represents a significant barrier for many people and families who struggle with mental health issues. Providers of Full Service Partnerships, and the providers for many of the other services within the Los Angeles County CSS Plan, will need to develop effective mechanisms for addressing transportation needs within their service delivery plans.

PART II, SECTION VI: Developing Work Plans With Timeframes And Budgets/ Staffing Projections

Sub-section I. Summary Information on Programs to be Developed or Expanded

1) Please complete Exhibits 1, 2, and 3, providing summary information related to the detailed work plans contained in the Program and Expenditure Plan.

Exhibits 1, 2 and 3 have been completed and are attached.

2) The majority of a county's total three-year CSS funding must be for Full Service Partnerships. If individuals proposed for Full Service Partnerships also receive funds under System Development or Outreach and Engagement Funding, please estimate the portion of those funds that apply toward the requirement for the majority of funds during the three-year period. (Small counties are exempt from this requirement until Year 3 of the three-year plan.) Please provide information demonstrating that this requirement has been met.

Attachment 2 contains a summary budget for our requests. We estimate that 65% of funds in FY 2005-06 will go to Full Service Partnerships; 63% in FY 2006-07; and 59% in FY 2007-08. We further estimate that at least 53% of our one-time fund requests will benefit people in Full Service Partnerships.

3) Please provide the estimated number of individuals expected to receive services through System Development Funds for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.

In FY 2005-06, we project that 1,083 people will receive Full Service Partnerships, and 17,752 people will receive services through our Systems Development investments. Please see Exhibit 6 for the detailed calculations supporting this projection.

We further project that the following percentages of Systems Development dollars will benefit people receiving Full Service Partnerships and their families:

- 92% of Children's Systems Development dollars;
- 38% of Transition Age Youth Systems Development dollars;
- 29% of Adult System Development dollars;
- 7% of Older Adult Systems Development dollars; and
- 12% of Alternative Crisis Services Systems Development dollars, spread across all four age groups.

Please see the budget in Exhibit 2 for the detailed calculations supporting these projections.

In FY 2006-07, we project that 4,333 people will receive Full Service Partnerships, and 51,678 people will receive services through our Systems Development investments. Please see Exhibit 6 for the detailed calculations supporting this projection.

We further project that the following percentages of Systems Development dollars will benefit people receiving Full Service Partnerships and their families:

- 92% of Children's Systems Development dollars;
- 38% of Transition Age Youth Systems Development dollars;
- 29% of Adult System Development dollars;
- 7% of Older Adult Systems Development dollars; and
- 11% of Alternative Crisis Services Systems Development dollars, spread across all four age groups.

Please see the budget in Exhibit 2 for the detailed calculations supporting these projections.

In FY 2007-08, we project that 4,333 people will receive Full Service Partnerships, and 54,438 people will receive services through our Systems Development investments. Please see Exhibit 6 for the detailed calculations supporting this projection.

We further project that the following percentages of Systems Development dollars will benefit people receiving Full Service Partnerships and their families:

- 92% of Children's Systems Development dollars;
- 38% of Transition Age Youth Systems Development dollars;
- 29% of Adult System Development dollars;
- 7% of Older Adult Systems Development dollars; and
- 9% of Alternative Crisis Services Systems Development dollars that are spread across all four age groups.

Please see the budget in Exhibit 2 for the detailed calculations supporting these projections.

4) Please provide the estimated unduplicated count of individuals expected to be reached through Outreach and Engagement strategies for each of the three fiscal years and how many of those individuals are expected to have Full Service Partnerships each year.

We have no clear method by which to make this estimate; however, we are able to provide the following statements at this time. Substantial portions of our early Full Service Partnership investments will be devoted to outreach and engagement. This commitment will be even stronger for providers who are focused on the focal populations for Transition Age Youth and Older Adults, where the infrastructures for Full Service Partnerships are far less developed than they are for Adults and Children.

Moreover, we are devoting substantial dollars each year—$3,317,000 in FY 2005-06 (including $317,500 in on-going funds and $3,000,000 in one-time funds), $1,000,000 in FY 2006-07, and $1,000,000 in FY 2007-08 to outreach and engagement efforts for unserved and underserved populations, particularly within ethnic and cultural communities and other special populations. We estimate that we will reach approximately 45,000 people through these efforts over the next two and a half years, and that some of these people will benefit from the services provided through our Systems Development investments, our Full Service Partnership investments, or both.

5) For children, youth and families, the MHSA requires all counties to implement Wraparound services, pursuant to W&I Code Section 18250, or provide substantial evidence that it is not feasible in the county, in which case, counties should explore collaborative projects with other counties and/or appropriate alternative strategies. Wraparound programs must be consistent with program requirements found in W&I Code Sections 18250-18252. If Wraparound services already exist in a county, it is not necessary to expand these services. If Wraparound services are under development, the county must complete the implementation within the three-year plan period.

Wraparound services already exist in Los Angeles County.